

Saskatchewan Health Stakeholders and the 1991-96 Wellness Program: The Politics of Implementing Health Reform

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Abstract

Powerful, entrenched health care stakeholders played a major role in limiting the health reform initiative of the Government of Saskatchewan in the 1990s. The politics of the decade was dominated by the fiscal crisis which prompted the government to embark on health care reform at the same times as it limited the scope of the reform. The narrative of Saskatchewan's health reform efforts showed that the government focused on the politics of health care, specifically the need to manage the diverse and often competing interests of health care stakeholders. It also reveals the dynamic between the stakeholders, the press and public opinion. As health stakeholders expressed their concerns about health care reform, the press and the public became more critical and the government backed away from its commitment to health reform.

Preface

My interest in health care reform is rooted in my leadership role at the Saskatoon Community Clinic. I have also been an employee of the Government of Saskatchewan, including five years in a Minister's office and twelve years as an official in a government department. Both have shaped my understanding of government and political processes.

I would like to thank my supervisor, Janice MacKinnon, who was Finance Minister from 1993 to 1997. She has provided valuable insights into government and political processes.

Terminology

Average Daily Census	ADC
College of Physicians and Surgeons of Saskatchewan	CPSS
Canadian Union of Public Employees	CUPE
Established Program Financing	EPF
Gross Domestic Product	GDP
Health Providers Human Resource Committee	HPHRC
Health Reform Labour Transition Coordinating Committee	HRLTCC
Health Reform Transition Program	H RTP
Health Services Utilization Research Commission	HSURC
Health Sciences Association of Saskatchewan	HSAS
Labour Relations Review Committee	LRRC
Labour Relations Board	LRB
New Democratic Party	NDP
Provincial Health Council	PHC
Regina Hospital Executive Planning Committee	RHEPC
Rural Health Advisory Committee	RHAC
Rural Health Coalition	RHC
Saskatoon Services Health Authority	SHSA
Saskatchewan Association of Health Organizations	SAHO
Saskatchewan Association of Special Care Homes	SASCH
Saskatchewan Association of Rural Municipalities	SARM
Service Employees International Union	SEIU
Saskatchewan Federation of Labour	SFL
Saskatchewan Government and General Employees Union	SGEU
Saskatchewan Home Care Association	SHCA
Saskatchewan Medical Association	SMA
Saskatchewan Registered Nurses Association	SRNA
Saskatchewan Rural Health Advisory Committee	RHAC
Saskatchewan Union of Nurses	SUN
Saskatchewan Urban Municipalities Association	SUMA
Service Employees International Union	SEIU

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Chapter 1: Introduction

Between 1991 and 1996 the Saskatchewan New Democratic Party (NDP) government of Premier Roy Romanow implemented Wellness, one of the most significant health reform initiatives undertaken by a provincial government.¹ Wellness aimed to remake Saskatchewan's health system. Its key goals included:

- (1) ensuring health is a priority for all sectors of the province through the development of health public policies;
- (2) ensuring effective and affordable service delivery through the integration, coordination and consolidation of existing services;
- (3) empowering people, communities and health professionals by increasing meaningful participation in the system;
- (4) strengthening family and community-based support and community-based approaches as alternative to institutional care;
- (5) enhancing health promotion and disease prevention to help people make healthy choices;
- (6) maintaining essential and appropriate care services;
- (7) developing alternative approaches, innovations and systems to enhance and support our new health system; and
- (8) enhancing health research and evaluation to strengthen decisions about our health system.²

As a result, Wellness was far reaching and, consequently, affected Saskatchewan's health stakeholder community.

Understandably, reaction to Wellness was significant. Yet, Saskatchewan's health stakeholders' initial response was not uniform: some supported the initiative, while others were opposed. Moreover, as Wellness evolved, so too did their views. Unfortunately, the nature and importance of these stakeholders, their dynamic and complex relationship with Saskatchewan's government, and their shifting views have been overlooked in the scholarly analysis of Saskatchewan's 1990s health reform experience. Thus there is an imperfect understanding of how and what shaped the Wellness agenda and why the desired policy outcomes failed to emerge. This thesis enhances previous scholarly work on Wellness by inserting Saskatchewan's health stakeholders into the story to demonstrate that they were a

central, catalyzing element of the health reform process, and that the NDP government understood their importance and molded health reform accordingly.

Although much has been written about the evolution of Canadian health policy, this thesis is not about changing health policy, but it is about the politics of health care. It argues that Saskatchewan's health reform policy, or Wellness, was shaped by two key forces outside the control of government: a fiscal crisis and Saskatchewan's health stakeholder community. This thesis will also document the dynamic relationship among stakeholder views of Wellness, press coverage of it and public reactions to the reform initiative and the government.

Political scientist Harvey Lazar indicated that it is necessary to acknowledge that once a policy direction has been chosen, its implementation is shaped by a number of forces internal and external to the control of government.³ It is, according to Lazar, these external forces which prove to be the main variable in determining the size of reform and whether reform's implementation will succeed. A number of scholars support this view and collectively have identified key forces to be interested groups (i.e. affected stakeholders, policy community, media opinion, etc.) and external dynamics (i.e. fiscal restraint, economic indices, institutional structures, etc.).⁴ When these factors converge they exert significant pressure on governments and force them to implement a new, or shift or end an existing policy direction. A tradeoff was noted by political scientist Ellen Immergut in her study on the health policy experience of three European countries. She observed that when faced with similar conflict from the health stakeholder community, different forms of institutions led governments to adjust their policy decisions and that each government did so out of political convenience as opposed to sound policy.⁵

The idea that tradeoffs and intermediation are an integral part of the policy process recognizes that governments are not the only actors involved. Nor do governments restrict their interactions to only one or two powerful actors. A more representative model, therefore, is that of a policy community which suggests a broader set of actors and groups are involved in the policy process and that their intermediations are complex. While the term “policy community” is a much discussed one, for the purposes of this study the work of two sets of Canadian political scientists will be used. William Coleman and Grace Skogstad argued that a policy community, such as that within the health sector, consisted of a set of actors, public and private, that coalesced around an issue and shared a common interest in shaping its development over the long run.⁶ Similarly, Paul Pross defined a policy community as “...groupings of government agencies, pressure groups, media people, and individuals, including academics, who for various reasons, have an interest in a particular policy field and attempt to influence it.”⁷ Pross’ community represented the large milieu of policy making activities in a specific field.

Pross then divided the members of his community, based on their relative positions in the decision making process, into the *sub government* and *attentive public*. The *sub government* was composed of relevant government departments, institutional groups and organizations routinely involved in the policy development process.⁸ The *attentive public* was a loosely defined group representative of those indirectly affected by or associated with the policy process. While very attentive to the policy process, they only become involved when necessary.⁹

In Saskatchewan during the 1990s, the health community consisted of a complex, dynamic population of stakeholders. The *sub government* was a sizeable, robust collection of

interests, many of whom were well-established and well-funded. Hospitals, health boards, powerful groups like the Saskatchewan Union of Nurses (SUN), the Saskatchewan Medical Association (SMA), health labour unions (i.e. Service Employees International Union [SEIU] and Canadian Union of Public Employees [CUPE]), and health advocacy groups, such as the Cancer Society were included. Two members of the sub government, SUN and the SMA, towered above others in size and power and thus had an important role in the reform process.

In 1991 SUN, a highly organized and militant union represented the majority of Saskatchewan's 9,507 registered nurses and the largest percentage of the health workforce. Nurses were also the primary employee group in hospitals (acute care), long-term and home care facilities.¹⁰ Since SUN's inception it had participated in nine sets of labour negotiations, led five strike votes and four strikes - 1974, 1976, 1988 and 1991.¹¹ SUN was also an active participant in the acrimonious union rivalries involving CUPE and the Saskatchewan Government Employees Union (SGEU) that characterized health sector bargaining relations. All three represented professional nursing staff.

SUN's approach to reform was pragmatic. It believed that historically the government had catered to physician's demands and would continue to do so. Hence it worried that health reform was nothing more than acute care cutbacks and token cost restraint.¹² Yet, SUN was also supportive of the principles of Wellness. Moreover, reform could be an answer to nurses' longstanding demands.¹³ These included increased wages, shorter hours, reduced workloads and recognition for their growing responsibilities and central role in patient care.¹⁴ Hence, as long as reform delivered these benefits to nurses, they were a potential powerful, supportive voice.

Saskatchewan's 1,495 physicians, represented by the Saskatchewan Medical Association (SMA), were the other major stakeholder in Saskatchewan's health system.¹⁵ While physicians represented 6.7 percent of Saskatchewan's health providers,¹⁶ they were responsible for 85 percent of total expenditures through their control over referrals to specialists and hospital admissions.¹⁷ Over the years, government payments to physicians had increased substantially due to a growth in physician numbers and corresponding utilization.¹⁸

Physicians feared that Wellness would erode their incomes, attack their fee-for-service remuneration, and compromise their autonomy.¹⁹ Yet, physicians also viewed Wellness positively. It offered improved system efficiency and service coordination. More importantly, physicians were confident that the government would not act imprudently. Simply, there was a history of past governments avoiding confrontation, in large part, because the 1962 Medicare strike had left an indelible scar on government-physician relations and on the public of Saskatchewan.²⁰ Also, physicians' willingness to defend their interest had in recent years been demonstrated by very public, confrontational job actions in other provinces.

Saskatchewan's health community also contained a large *attentive public*, including the public at large, the media and numerous *ad hoc* groups ready to materialize in response to specific issues and concerns. During Wellness this *attentive public* became influential participants in the policy discussion.

An example of a very important *ad hoc* group that emerged was the province-wide Rural Health Coalition (RHC), which represented the interests of communities in rural Saskatchewan. Often times, rural communities, defined as rural centres with fewer than

5,000 people, organized themselves to advance their political interests. An example of this approach is the Saskatchewan Association of Rural Municipalities (SARM). The rationalization of health services that was part of Wellness hit rural communities especially hard; for instance, 51 of the 52 hospitals closed in 1993 were in rural locations. The vast majority of these communities expressed their disapproval of Wellness in newspapers, petitions and with public protests. Since the government held many of these seats it was concerned about its future electoral prospects, and thus paid close attention to rural views and concerns. This made all communities in rural Saskatchewan important, but it also elevated the status of *ad hoc* groups opposed to Wellness, such as the RHC.

Other noteworthy members of the *attentive public* included urban communities and the public-at-large. Each shared similar concerns over hospital and bed cuts and likewise responded with petitions or by forming coalitions such as the Concerned Citizens for Health Care in Prince Albert. Importantly, the media was a central messenger for the *sub government* and *attentive public*, and as well, a key commentator on Wellness. This commentary became a bellwether for the government.

Political scientist Antonia Maioni discovered in her research that *ad hoc* actors, or external organizations such as labour, farmer and church groups, and political parties, were the forging forces of Medicare.²¹ Their continued involvement and pressure upon governments ensured the politicization of health care and explained why non health stakeholders were an important element in the reform story and in Pross' *attentive public*.

While the health community concept captured the vibrant nature and complexity of the province's health environment, the term stakeholder and its related theory is a relevant tool to describe individual participants of this community. The leading scholar in the field,

R. Edward Freeman, defined stakeholders as groups or individuals who affect and are affected by a policy objective.²² The term stakeholder includes a broad base of people made up of those who do, and those who do not expect to make personal gains in their issue advocacy. This aptly represents the breadth of Saskatchewan government-health stakeholder relations. Wellness awoke both organized health stakeholders and unorganized latent stakeholders who fit within Pross' *sub government* and *attentive public* constructs.

Health stakeholders were also not a homogeneous group. That is they represented a mixture of different views and played differentiated roles in the policy process. A stakeholder's support for a policy direction was linked to its self interest. So long as they could accrue benefits, no matter the extent of the changes, stakeholders remained supportive. Thus, during Wellness some stakeholders supported reform's direction because they gained, while others opposed because they lost. Moreover, their views were not fixed.²³ With each new policy direction or decision by the government, a stakeholders' reaction to reform shifted as the associated benefits disappeared or improved. This meant that Saskatchewan's health community held divided opinions throughout most of the evolution of Wellness. As a result, a window of opportunity existed for reform. The window closed when stakeholders unified their opposition in 1996.

Another important variable in reform policy making, and especially in health policy, is that it is a political process. Governments, and in particular politicians, must be able to muster support for their decision. Political scientist, Michael Howlett, noted that policy shifts are the outcome of interactive processes and balancing acts between power relationships and prevailing ideologies.²⁴ The end goal is to achieve a more or less lasting solution with limited stakeholder-stakeholder and government-stakeholder conflict.²⁵ This

means that each stakeholder, including the government, will not only act independently, but will negotiate, refine positions and identify compromises to suit its particular views.

The NDP government understood the intricate and sensitive nature of its relationship with stakeholders. An examination of Saskatchewan's health reform story illustrated that the NDP government, from the very beginning, knew health reform would be intensely political and that the government needed to lead and manage the process.²⁶ Saskatchewan's health sector represented the province's largest workforce and health sector wages consumed between 60 and 70 percent of all provincial government health expenditures.²⁷ Nine well-organized and well-financed unions represented a large majority of these health care workers, with 95 percent as members of only three of the unions: CUPE, SEIU and SUN.²⁸ Many health stakeholders were also members of professional associations. These associations elevated health workers status, and gave them access to higher wages and more responsibility, and a more powerful voice. In some cases, health stakeholders belonged to both a professional association and a union since unionization provided a channel to promote their professional demands.²⁹ As a result, Saskatchewan's health policy process occurred within a very volatile setting consisting of many stakeholders.

Moreover, this stakeholder community, especially physicians and nurses, possessed significant credibility with the public relative to politicians, and because stakeholders were organized, they became the main commentators on the health reform process. Thus, their public support or neutrality or opposition powerfully impacted upon the media and the public's views of reform. The sheer size of the health stakeholder community, an enduring resentment over Saskatchewan's bitter Medicare strike thirty years prior, a propensity to strike and high levels of union and professional militancy made it formidable. As a result, by

the 1990s Saskatchewan's government-stakeholder relations existed in a state of constant tension that had impeded and continued to impede, needed policy shifts.³⁰ Equally, changing the health system required more than sound policy; it required a focus on the political management of stakeholders.³¹

By 1991, this longstanding *status quo* was no longer tenable mainly because it was no longer financially sustainable. While it is true that the government's decision to proceed with Wellness was influenced by the fact that the health system was disorganized, inefficient and unable to provide efficacious care for Saskatchewan people, it is critical to remember that previous governments had been told in various reports about these problems, but had failed to take decisive action. What was different in the 1990s was that the fiscal crisis in the province and the financial problems with health care left the government little choice but to take bold action. Reform therefore became Saskatchewan's policy tool for managing uncontrolled health expenditures.

Change, as political scientist Stephen Tomblin observed, is difficult to bring about in entrenched health systems when an "...old regime remains strong, underlying structural conditions do not change, and there is little opportunity to contest established monopolies...."³² In this type of environment, political scientist Carolyn Tuohy and Tomblin suggested that change was only possible alongside a critical juncture,³³ or a marshalling force.³⁴ This force or juncture could be the arrival of a new more powerful health stakeholder dominant enough to shift the balance of power, or alternatively, an external power or shock sufficient to coerce change. The NDP government found the necessary motivation for health reform in the form of Saskatchewan's fiscal crisis.³⁵

The fiscal crisis was the critical event or marshalling force that overturned the health system's *status quo* and supplanted health stakeholders' interests. This crisis forced the government towards the difficult components of Wellness. Thus reform became the policy tool for managing uncontrolled health expenditures. It involved comprehensive change - increased efficiency, management and accountability, and cost-cutting - embedded within structural reorganization, realignment of the system away from the medical model and towards a focus on health promotion, and prevention and community-based care.³⁶ Consequently, restoring fiscal stability to the province went hand-in-hand with reforming the health system.

The context for this thesis is the fiscal crisis of the 1990s and the role of stakeholders in health reform. Much of the literature on the fiscal crisis of the 1990s focuses on the origins of the crisis and its magnitude.³⁷ By the 1990s interest on the federal government's public debt was growing at an unsustainable and alarming rate of \$100 million a day and in January 1995 the internationally recognized business newspaper *The Wall Street Journal* published an editorial entitled "Bankrupt Canada?"³⁸ At the federal level, the fiscal crisis was addressed in the 1995 federal budget which included dramatic cuts in spending, including major reductions in funding for health care and other social programs.³⁹ At the provincial level, a major financial publication wrote in 1992 that the "...fiscal situation ranges from painful in Quebec, to ghastly in Ontario to terrifying in Saskatchewan."⁴⁰ The fact that Saskatchewan's total debt was \$14.8 billion, the highest per capita debt in all of Canada,⁴¹ meant that the province faced a fiscal crisis that required immediate and bold action. The 1992 and 1993 budgets introduced dramatic spending cuts and tax increases

which were widely supported by the public which had come to understand the magnitude of the fiscal crisis and the need for action.⁴²

The literature on the fiscal crisis in Saskatchewan is similar to the material about the national scene: it focuses primarily on the magnitude of the problem and the measures adopted to address the crisis. Janice MacKinnon's work is a well-researched account of the origins of the crisis and an insider's view of how the Romanow government dealt with the daunting task of eliminating the deficit.⁴³ However, the focus is on the cuts made, rather than the opportunities presented by the fact that the public supported the need for bold action in the name of deficit reduction. Also, the book is more narrative than analytical and it says little about health care reform.

Another book on the topic is Deficit Reduction in the Far West: The Great Experiment, contains articles on the handling of the deficit reduction in Canada's three most western provinces.⁴⁴ One article by Richard H.M. Plain compares health reform, health care spending and health status in the three provinces and concluded that "Saskatchewan developed the prototype model for the rapid and successful reform of a provincial medicare system."⁴⁵ Plain focuses on regionalization and the development of needs-based funding as the major achievements of Saskatchewan's reform initiative, while he pointed out that the government failed to make progress in changing the way doctors were paid and he noted that the health status of Saskatchewan people declined during the deficit reduction period. While interesting, Plain's work said nothing about the role of health stakeholders in the reform process and he mentioned that deficit reduction was a driving force in the government's decision to embrace reform without providing a detailed explanation of his argument.

Another publication that linked deficit reduction and health reform is an article by Duane Adams, the deputy minister of health who oversaw the Wellness process. Adams linked deficit reduction and health reform.⁴⁶ He argued that deficit reduction and health reform competed for pre-eminence on the government's agenda and the victory of deficit reduction meant that the fiscal crisis helped to undermine Wellness; for instance, there was a fundamental contradiction between Wellness's emphasis on community decision-making and the unilateral decision by the government to close 52 hospitals. Adams emphasized the constraints placed on health care reform by the fiscal crisis but ignored the opportunities presented by the fact that the government had to take bold action and the public was receptive to such action in the name of deficit reduction. Also, Adams failure to comment on the government's management of its health stakeholders leaves a large gap in his analysis. His personal involvement in the health reform process may have made him reluctant to admit that the government was methodical, even ruthless in its management of Wellness.

Hence, what is lacking in the literature on deficit reduction and health reform is an understanding of the opportunities presented by the fiscal crisis. The single most important reason when the Romanow government embraced health reform, while other governments had failed to act, was the fiscal crisis facing Saskatchewan and the fiscal problems with provincial health spending. Moreover, in its messaging the government effectively used the fiscal crisis to garner public support for health care reform.

The fiscal crisis in Saskatchewan was acerbated by the unsustainable increase in health care costs. The fiscal problem with health care was documented in an article by Paul Boothe and Mary Carson and in a piece by Janice Mackinnon, entitled "The Arithmetic of Health Care."⁴⁷ Health care spending is unsustainable since it is growing at a faster rate than

the growth of revenue of any government in Canada. Hence, it takes a bigger and bigger piece of the government spending pie, with the eventual result being that 100 percent of government budgets would have to be devoted to health care. Ontario Premier Dalton McGuinty highlighted the unsustainability of health care costs: he said, “There will come a time when the Ministry of Health is the only Ministry we can afford to have and we still won’t be able to afford the Ministry of Health”.⁴⁸ An additional problem is that the growth in health care spending has crowded out funding for other areas such as education and poverty reduction programs which are essential to promoting a healthy population.

What has been overlooked in the work of Boothe, Carson and MacKinnon is the fact that while the fiscal crisis of the 1990s was acute, the fiscal problems with health care were chronic. That is, by the early 1990s the fiscal situation of provinces like Saskatchewan had deteriorated to the point that there was doubt about the government’s ability to borrow money to fund its operations. For this reason, immediate action was essential. In contrast, while the government had to act to limit the growth in health care spending, the fiscal problems in health care unfolded gradually over an extended period of time and could, therefore, be left for future governments to tackle. Thus, while the fiscal crisis opened the door to health reform, the improvement in the province’s finances and the resulting aggressive resistance by stakeholders made it easier for the government to abandon health care reform and leave it for another day.

As well as the fiscal crisis, the role of stakeholders in the health reform process provides the other main context for this thesis. As mentioned previously, the emphasis in the thesis is on the politics of health reform. There is a vast body of literature on the public policy issues involved in health reform. Though interesting, this literature focuses on the

content and not the context of reform. Thus it does not provide the foundation for this thesis. Instead, the focus is on the stakeholder groups involved in health care and the dynamic that played out between them and the government as Wellness unfolded.

What is remarkable in the literature on health reform in the 1990s is how little attention has been paid to the implementation process of health reform and the role of health stakeholders in that process. The extensive research on health reform by Greg Marchildon, Deputy Minister to the Premier (1996 – 2000) in Saskatchewan's NDP government focused on policy issues. Though he acknowledged the importance of the fiscal crisis, Marchildon preferred to analyze the tenets of the NDP government's policy objectives - community empowerment, wellness and regionalization. He said little about the actual implementation of the reform and the role of health stakeholders. Like Adams, he gave short shrift to the fact that the implementation of Wellness involved a well planned and strategic process centred on enhancing government control, improving costs and service efficiency and accountability, and reducing the power of stakeholders.

Kevin O'Fee, another participant in Saskatchewan's reform, offered a detailed discussion on federal provincial relations and the fiscal crisis, ably noting the historical importance of each and how it contributed to Saskatchewan's 1990s health funding problems. The other valuable aspect of his work was the extensive interview with Duane Adams that provides an "insiders" view of the management and goals of Wellness and in particular of the contradiction between Wellness' holistic health system goals and the harsh fiscal goals. Unfortunately, he like others failed to obtain from Adams any sense of the governments' views and approach to stakeholders. More importantly, O'Fee's provides only

a cursory analysis of events after 1993, when in fact, the more substantive streams of reform were implemented.

Overall, these discussions suggested only a cursory consideration of health stakeholders' role in the reform process. It may be that analyzing stakeholders required a more intimate understanding of their motivations than is possible from the senior level civil servant background of the aforementioned scholars. This may explain why labour scholar Kurt Wetzel provided the only informed discussion and analysis on health stakeholder experiences during Saskatchewan's health reform. While Wetzel alluded to the importance of the fiscal crisis, his years working with unions enabled him to create a fuller analysis and as well, to speak directly to the motivations and views of Saskatchewan's stakeholders. They in essence, were not the enemy. In fact, Wetzel noted, health stakeholders supported many aspects of the reform and even believed Wellness to be necessary for both improving the system and for achieving their own goals.⁴⁹ In addition, he attributed the government's successful implementation of reform to a proactive yet sympathetic stakeholder management approach that secured their buy-in for reform. Wetzel also suggested that the process failed because the government could not manage the size of the changes and thus ease the fears and apprehensions of stakeholders. While an insightful analysis, Wetzel's work failed to account for the depth of stakeholders' hesitance to reform and thus the fundamental role of the fiscal crisis in guiding stakeholders through the reform process. Moreover, while stakeholders acknowledged the need for change, he fails to note that these stakeholders reacted to reform because changes meant that under reform, the government intended to exercise more control and management over health stakeholders and the health system.

Political scientist Alan Davidson also failed to consider the role of the fiscal crisis in health reform in the 1990s. However, he is worth mentioning because he has provided the only analysis integrating health stakeholders into the reform story and specifically, the British Columbia's (BC) health reform story. His role as a civil servant during BC's reform, better informs his understanding of the mechanics of health reform that can be applied to Saskatchewan's experience. Davidson argued that BC's reform efforts clearly intended to attack health stakeholder's preeminent position in the BC health system and gain control of the health system. The government wanted to reduce the power and authority of health ministry bureaucrats, health care managers, and health care professionals.⁵⁰ Knowing resistance was inevitable, BC used a methodical process to gain public support to overcome stakeholder resistance. This included promotion of community based local boards and terms like health promotion. Unfortunately, Davidson's articles were too brief to provide an in-depth analysis of the role of stakeholders in reform and an understanding of the dynamics of the reform process.

Thus, the fiscal crisis and the dominant role played by stakeholders in health reform provide the framework for this thesis. Wellness was a fiscal agenda which intended to curb unsustainable spending and infuse more control over the health system, couched within a broader framework of health reform.⁵¹ Cost cutting and cost management increased efficiency. Accountability was the end product of reorganization and needs-based funding. A realignment of the system away from the medical model and towards a focus on health promotion and prevention grew from greater community engagement.

Stakeholder resistance was understandable. Sociologist Harley Dickinson posited, by its nature health reform would alter government-stakeholder relations and entrenched

stakeholder structures.⁵² Achieving health reform therefore required government management of stakeholders and it is here that the true ingenuity and distinguishing feature of the NDP government's health reform story emerges. The NDP provided political leadership to a highly politicized health environment and policy process.⁵³ Accordingly, a strategic approach to stakeholder management became the most important mechanism of the NDP government's Wellness initiative. On the whole, the government's goal was to prevent health stakeholders from derailing Wellness' agenda. Deputy Minister of Health Duane Adams noted that containment of stakeholders was essential as the government understood that there could not be "...meaningful reform of the health system without diminishing and constraining the negative effects of...vested interests."⁵⁴ This necessitated the creation of a strategic, yet flexible, well planned process that respected each stakeholder's behaviours, interests, motivations, relations and resources.⁵⁵ The narrative of Saskatchewan's Wellness experience illustrated that the NDP government's strategy for implementing health reform was straightforward and focused primarily on the management of the political nature of the process and of health stakeholders.

One of the first steps was to protect the already established good will between the government and the majority of health stakeholders. A long-standing alliance between the NDP party and organized labour tempered initial and potentially devastating resistance. Stakeholders were convinced, based on the NDP's history as the founders of Medicare and its past relations with labour, that Wellness' goals could coincide with their own. As long as this alignment existed stakeholders either supported or were neutral towards the government's health reform agenda. Consideration of these relations remained a constant element of Saskatchewan's health reform.

Another key mechanism employed from the beginning was communications and messaging. Communications with the public and stakeholders aimed to garner support for the Wellness process and goals. A more important tool was messaging, with its multiple of purposes. First and foremost, it linked health reform to the fiscal crisis and ensured everyone accepted the legitimacy of the crisis and thus the inevitability of reform.⁵⁶ This galvanized health consumers' and citizens' support for health reform.⁵⁷ So long as public support aligned with health spending restraint, stakeholders lost an important ally.⁵⁸

Messaging also focused on promotion of the positive aspects of health reform. Wellness' tag lines masked the harsh realities of the changes necessary. Across-the-board cuts to health were couched in holistic goals congruent with a broader community-based innovative health agenda. Prevention and promotion, and improvements to the social, the environmental and the economic factors impacting upon a person's health were emphasized.⁵⁹ Saskatchewan's reformed system promised a better organized system that provided improved patient care and better utilized health professionals.⁶⁰ Wellness offered Saskatchewan people and health stakeholders a better health system. Who would not support these lofty goals? Importantly, messaging assured people that Wellness was about more than cost cutting.

Moreover, the government actively took ownership of the information on Wellness. A mountain of literature and supporting documents explaining and promoting health reform was developed and disseminated by the government. Each of these pieces highlighted that health spending was unsustainable and reform of the health system was an imperative.

Conflict with stakeholders was diffused via a proactive and wide-reaching political engagement process.⁶¹ At the beginning of the reform process, communities and health

stakeholders were invited to take part in shaping their reformed health system.⁶² Then throughout the process, health stakeholders, and especially organized labour, was welcomed onto committees. As well, conferences were sponsored and public meetings held.⁶³ Moreover, when an issue arose, the government formed another committee or held another discussion. Essentially, the government strove to enhance understanding, build collaboration and maintain relationships.

The government also demonstrated a willingness to be flexible with stakeholders. Stakeholders' concerns were accommodated when it was possible and in alignment with the power and influence of the stakeholder. This meant that the government's flexibility reflected a stakeholder's position in the hierarchy. Physicians and organized labour sat at the apex, with the unorganized at the bottom. SUN superseded CUPE and SEIU. Rural Saskatchewan received less consideration than physicians or nurses. Unfair as it seemed, this approach effectively set the parameters for the compromises with stakeholders deemed necessary to see Wellness through. Ultimately it also meant the government moved away from the more divisive elements of reform, such as salaried physician remuneration.

Wellness' roll out was also preplanned, controlled and methodical.⁶⁴ Although this contradicted the much ballyhooed community-based leadership of the process, the government appreciated that success essentially meant that reform's execution had to be organized. Therefore reform was a process that unfolded in two stages with the transition to the second stage conditioned on completion of the first stage.⁶⁵ Notably, both stages imparted significant changes for stakeholders.

The first stage, consisting of six pillars, was structural reform. Two pillars were put in place in the early months: the Health Services Utilization Council (HSURC), a research

organization, and the Provincial Health Council (PHC), a health stakeholder council. Interestingly, both were research-based organizations which played a seminal role in providing an independent, credible voice supporting the tenets of Wellness and health reform.⁶⁶ These organizations stood as obstacles to anyone who challenged the value of Wellness.

The unveiling in August 1992 of the concept paper, A Saskatchewan Vision for Health: A Framework for Change, was the third pillar. The document set out the fundamental beliefs, values and overarching goals for the reform process.⁶⁷ As this was a prescription for reform, stakeholders and the public were left with little to attack and much to support.

The fourth pillar was regionalization; one of the flagships of Wellness. This involved the merging of existing services and governance structures into new health districts. Community planning committees began work on forming health districts in early 1992, well before the release of A Saskatchewan Vision for Health. Regionalization was to be completed by August 1993. Saskatchewan's health map would be redrawn and the plethora of autonomous long-standing health boards merged into a manageable number of larger health districts with a reduced number of boards.⁶⁸ This restructuring was heralded as a mechanism to eliminate redundancies, create economies of scale, improve local health services, and produce new levels of coordination and efficient provision of health services across the province.⁶⁹ Regionalization also embraced home based care, which shifted patients out of expensive institutions and hospitals and into their homes. As rural communities required health care, though not necessarily delivered via expensive hospitals, wellness centres were the answer to hospital closures in rural towns.

Once districts were in place, the fifth and other flagship of reform, needs-based funding, was implemented. The new formula was a methodical population-needs approach that linked funding levels to the demographics and health care requirements of a local population.⁷⁰ Previously, boards operated under an inefficient long-standing formula based on volume, services offered and historic expenditures, with no built in accountability mechanisms.⁷¹ Many scholars and health workers supported the needs-based approach as a better alignment of dollars to real service needs.⁷² More importantly, the formula enhanced oversight and local control by requiring community-elected Districts Boards to assess and then develop performance metrics for their communities; mechanisms by which the community could then hold them accountable. Again, the formula was heralded as a theoretically sound tool that would lead to better services and use of health dollars. Likewise, the transfer of employees from the Department of Health to the districts, which coincided with the implementation of this new funding formula, logically followed as a mechanism to shift resources from the government into the hands of communities. Both the transfer and the funding formula had a completion date of April 1995.

The final pillar was health board elections in late 1995. These were championed as the machinery for community engagement. More importantly, they represented the handover of responsibility and ownership of health services, including responsibility for local health stakeholders, to local communities. Elections also signaled the completion of stage one.

Reform's focus then shifted to the second stage, the core of renewed primary health care and an equally divisive component of health reform.⁷³ Based on contemporary leading edge research, this stage transitioned Saskatchewan's health system from the medical model to a population health and health promotion approach.⁷⁴ Like many other streams of reform,

these concepts and approaches also had the support in principle of stakeholders in Saskatchewan's health community.

Under primary health care many physician-provided services were to be delivered by ancillary health workers such as nurses and social workers. Moreover, primary health care promoted the integration of health services. Teams, not physicians, delivered health services and shared decision making responsibilities. As a result physicians faced challenges to their scope of responsibilities, while ancillary workers saw new job classifications and career opportunities established.⁷⁵ Wellness also promoted the adoption of new diagnostic testing, treatment methods and other advanced technologies, importantly, delivered by less costly technicians instead of physicians. On the whole, these innovations better utilized existing skill sets such as those of nurses, while shifting emphasis (and resources) away from costly physician-based services to cost effective and less institutional community-based care such as home care.

Health reform also opened the door to shifting physicians away from fee-for-service remuneration. Many ancillary health workers advocated alternative physician remuneration schemes since, they argued, these schemes delivered more holistic health care relative to the existing system where physicians operated within the quantity versus quality based fee-for-service payment mechanism. As well, a large number of stakeholders believed alternative schemes reduced physician's autonomy and authority, and thus dominance in the system, while increasing physician oversight and accountability.

Finally, the government understood the dynamics and politics of Saskatchewan's health stakeholder community. Wellness and each of its pillars embodied significant negative change for health stakeholders. There was significant change, instability and uncertainty. For

example, the new funding formula was hard on rural communities as it decreased funding for many rural districts. This translated into rural hospital bed closures and job cuts and, needless to say, elicited hostile reactions from rural people across the province. Likewise, regionalization led to the firing of hundreds of board members and hundreds of historically independent and at times competing communities were amalgamated. Urban centres saw layoffs and service rationalization.

As a result, efforts were made to avoid being heavy handed. Appreciating that each stakeholder was motivated by self interest, the government first and foremost, worked to satisfy stakeholder interests, while at the same time counterbalancing one stakeholder against another. For example, while ancillary health workers were excited by the new opportunities that reform offered for their own careers, the government understood that they – especially nurses – desired more responsibility and recognition. Where rural people were angered by the loss of their hospital and health services, the government offered funding to support the transition. More often however, this opposition was countered by stories of rural towns and communities who supported reform, who welcomed the change. When physicians grew alarmed by plans to introduce alternative remuneration plans under Wellness, they became more receptive to Wellness once the government backed down. Thus, reform was a process of give and take which had the effect of dividing the stakeholder community, and leading to stakeholders having differing views on reform, even after bed cuts and closures.⁷⁶

More importantly, if the benefits of Wellness and catering to self interest failed to convince health stakeholders to continue to participate, the government adeptly returned to the fiscal crisis as the most important reason for enduring through the pain of reform. This context served to remind stakeholders, opinion leaders, the public and media that the

alternative was worse. It is therefore worth reemphasizing that the province's fiscal crisis opened the door for the government to upend an entrenched system and powerful stakeholders.

In its entirety, Wellness's expansive reforms resulted in far-reaching changes. It also increased the role and control of Saskatchewan's health system by the government. Regionalization centralized a previously decentralized, very community-based, and patchwork health system.⁷⁷ Oversight and province-wide coordination by the government increased. Needs-based funding allowed the government to retain control of setting the global funding levels for districts. Moreover, reform enabled the government to decisively close 52 rural hospitals while rationalizing health services across the province.

In the end the unwinding of health reform began with an improved provincial economy and the return of the government's financial health. Where the fiscal crisis opened the door to health reform, its disappearance effectively closed it. The easing of the fiscal pressures came as major stakeholders recognized that Wellness would not deliver promised benefits and held only more bad news (continuing job losses and increased workloads, attacks on member's autonomy and patterns of practice). A once divided stakeholder community converged and became singularly focused on vigorously opposing health reform. With more credibility in the public arena than politicians, the concerns of physician and nurses, voiced in the media, led to increased public unease and then opposition to reform. By 1996, the government could no longer contain its health stakeholders, the press was more critical of the reform initiative and together both turned public opinion against the government's reform agenda. As opposition to health reform increased the government's interest in pursuing reform abated. The dynamic between stakeholder opposition and public

opinion meant that by 1996 health reform had become a political liability for the government and this was the other main reason it was abandoned. Wellness ended five years after it began, well short of becoming anything more than a regionalization and resource management exercise.

As mentioned previously, the focus of this thesis is not on health care policy but on the politics of health care; hence, the sources relied upon are those most commonly used to study politics. Government documents and public statements by the Premier and Ministers were the main source for the government's perspective on reform. Unfortunately these sources do not provide insight into the debate that may have occurred within government ranks. However, this problem is unavoidable since all the documents on subjects such as this would be sealed because of their confidential nature. Another excellent source used was the reflections of Duane Adams, who was deputy minister of health during the period of Wellness. His own articles and his interviews in a thesis by Kevin O'Fee provided a rare "insiders" view of the management of Wellness. Hansard, which is the record of legislative debates and decisions, provided the best source for opposition reaction to reform and for studying the interaction between the government and opposition members.

Polling and the media were an extremely important source. It has to be stressed that the media sources were not evaluated on the basis of whether or not they accurately reflect events. Since this thesis is about politics the media is important because of its role in molding and reflecting public opinion. Most people relied on the media for their information about government initiatives like health reform and at least some read the editorial opinions and columnists' view of the government's decisions. Likewise, both the bureaucracy and government members carefully tracked media coverage of government's decisions. When the

legislature was sitting every government member received a daily package of media clippings covering newspaper and radio reporting. Polls were the other main source used by the government to gauge public opinion. These sources are important as a barometer of public opinion. They track the changes in critical press coverage of Wellness and illuminated the declining public support for the initiative, on the one hand and the government's reluctance to pursue further changes, on the other hand.

Lastly, a narrative and chronological approach has been adopted. This approach illustrates firsthand the interactions among the stakeholders, the media, and the public and how these changed over time. It also helps to depict the depth of anger and frustration by stakeholders with reform and why over time it was not possible for the government to manage the competing demands of the various stakeholders. Essentially, the government's management of stakeholders worked initially but as fatigue and cynicism set in over health reform, the old practices no longer worked and health care reform had to be abandoned, especially when the fiscal crisis ended.

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Chapter 2: The Beginning: Implementing Health Reform

As overviewed in chapter one, significant policy shifts depend on external or marshalling forces to overcome a policy community's adherence to the *status quo*. Such was the case in Saskatchewan's health community in the 1990s. In spite of a myriad of serious system-wide structural and financial challenges and issues, health reform emerged because economic and fiscal forces overwhelmed stakeholder resistance. Basically, until the 1990s fiscal crisis in Saskatchewan, politics trumped sound policy.

This chapter, covering the first two years of reform, demonstrates that from the beginning of its reform process the NDP government understood that health reform was more than a policy decision. It required an understanding of, more importantly, the opportunity presented by the marshalling force of the fiscal crisis, then the influence, interests and positions of its health stakeholders, and lastly, the necessity of implementing a strategic approach that involved managing the character and course of the reform process. In essence, the government grasped that reform was both a dynamic policy process and a political process. What is more, the latter was more important than the former.

By the election of 1991, with the Romanow NDP defeat of the Devine Conservative government, reform of Saskatchewan's health care system became inevitable. Devine's government had inherited a large, inefficient and expensive health system. Then he, like previous governments, failed to address these structural problems or to control health costs. Indeed, past governments used easy money from federal-provincial cost-shared programs to support the growth of the very problems with the system: hospitals and a reliance on the medical model. Ironically, even as these governments accepted these cost-shared funds, they expressed concern about health costs.

Devine appreciated that Saskatchewan's health system had expenditure problems and had even attempted to control health spending. However, political expediency impeded his efforts – keeping rural Saskatchewan and health unions content trumped the need for reform. Consequently, between 1982 and 1989, Saskatchewan's health expenditures grew to record levels. The health budget grew at an average rate of approximately 9.6 percent annually,¹ more than the province's annual gross domestic product (GDP) growth. More importantly, Devine's health spending choices were a problem. Millions went to building new hospitals, renovating existing ones, and adding acute and long-term care beds across the province.² Hospital operating budgets increased in lockstep. As a result, Saskatchewan had more beds and hospitals per capita than any Canadian province.³ Unfortunately, there was neither the rural population nor front-line staff and doctors to support these beds.⁴ As a result, when staff existed many either closed beds, or kept beds full and staff busy by increasing patients' average length of stay or by housing long-term care or chronically ill patients.⁵ Basically, Saskatchewan's health system grew at unsustainable rates with little correlation to improving the health of rural people.

At the same time, Devine faced a federal government that believed that Medicare had become too expensive. A program that cost \$300 million in 1962 and \$450 million by 1968, cost over \$2 billion in 1976.⁶ As a percent of Canada's GDP, total health costs grew quickly, rising from 4.6 percent in 1960, to 8.5 percent by 1986.⁷ Public health care expenditures threatened to overwhelm the system. The federal government responded by capping its contributions to health costs, thus shifting health costs onto provinces. For Saskatchewan this proved to be significant. The province was experiencing record health spending. At the same time, economic growth stalled as high interest rates, poor world

markets and a fall in commodity prices (grain, heavy oil, potash and uranium) converged with the misfortunes of nature (drought and an infestation of grasshoppers), reduced overall provincial government revenues.

Instead of aggressively cutting spending over his nine years in government, Devine turned to annual budget deficits and debt to support spending. With respect to the problem area of the health system, his government commissioned numerous studies and reports. These latter efforts aimed to convince the public and health stakeholders to lessen demands for more services and money, and to identify better, more efficient mechanisms for delivering health services. Devine also contemplated more emphasis on health promotion and population health, which, according to research, would improve the overall health of the population and result in cost savings. These ideas were advocated in a report, *A New Perspective on the Health of Canadians* (1975), developed in 1975 by Marc Lalonde, a federal Minister of Health. Lalonde encouraged governments to de-emphasize physicians and the medical model while investing in programs which created healthier lifestyles and better living environments.⁸ Adopting these programs, he proposed, created healthier people and thus saved the health system money. In a similar vein another federal minister, Jake Epp wrote *Achieving Health for All* (1986) which expanded on *A New Perspective*, emphasizing broader government investment in the social and economic determinants of health, such as housing and mental health programs.⁹ While both health promotion and population health received enthusiastic support from the health community, and even provincial governments, politics meant that the medical model and hospital infrastructure proved difficult to change. Devine, as well, lacked funds to support any new initiatives.

Devine's commissions and reports also met a similar fate, and most ended up shelved due to similar fiscal and political challenges. Nonetheless, each told a similar story about the problems in the health system. For example, in 1987 the Report on Enhancement of Regional Hospitals (Schwartz Report) called for the closure of Saskatchewan's system of small costly and inefficient rural hospitals. In 1989, The Growth in Use of Health Services, verified that the growth in the government's health expenditures had been "...dramatic..."¹⁰ and needed to be curtailed. Consensus Saskatchewan, a community based advisory group submitted a report that called Saskatchewan's health system inefficient, outdated and encumbered by escalating costs. The Commission on Future Directions for Health Care (Murray Commission), reporting in 1990, became the final and most extensive effort.

After extensive stakeholder and public consultation, the Murray Commission report described the Saskatchewan system as disorganized, inefficient, ineffective, and growing more costly by the year. At the same time, it had little impact on the health of Saskatchewan people.¹¹ Of the Commission's 262 recommendations, three proved significant.¹² The regionalization recommendation advocated merging over 400 discrete services, infrastructure and boards into 15 regional health-service divisions to reduce redundancies and to simplify convoluted management, governance and services.¹³ The report also recommended consolidation of Saskatchewan's 134 hospitals – especially rural hospitals and health services – and a shift to home-based and community care to create a more cost effective and efficient system.¹⁴ A final recommendation called for the adoption of new technologies, alternative health care models and evidence-based outcome measures to update the health system's reliance on a costly physician-based medical model. Implementing all of the Commission's

recommendations, and these in particular, produced a better system, which was more effective, more humane and more cost effective.¹⁵

None of these views were new. By the 1990s, other provincial governments faced similar issues of affordability and effectiveness. Each searched for ways to bring their health system under control, and, each undertook studies, all of which arrived at the same conclusions.¹⁶ Health spending needed to be slowed to safeguard provincial health programs. Physicians and the medical model were inefficient and costly.¹⁷ The system lacked integration and coordination and failed to provide a full continuum of care. Accountability did not exist.¹⁸ Moreover, the system placed the needs of stakeholders before that of the community. Each report also stressed that more money could not fix the problems.

In spite of all of these reports showing that health systems needed improvements and that Medicare in general needed to be changed, the Devine government stopped short of any significant action. This hesitation came even though Devine faced support for reform, notably from stakeholders such as SUN and the SRNA, who called the possibility of change exciting,¹⁹ and the Canadian Mental Health Association along with others who felt frustration with the system's inefficiencies.²⁰ Nonetheless, most health stakeholders feared change and, even more importantly for Devine, many rural communities responded with vigorous negativity. These reports and recommendations doomed them to hospital closures, termination of health services and the loss of jobs in their communities.²¹ Thus under Devine, health reform's fate became a matter of political expediency.

After ten years of poor spending decisions by the Devine government, both Saskatchewan's finances and its health system were in extremely poor shape.²² Nine years of annual deficits resulted in a significant and growing provincial debt, and meant that by 1991,

the province had one of the highest per capita debts in Canada and one of the lowest provincial credit ratings.²³

The NDP opposition and even the public understood these facts. A poll taken days before the 1991 election revealed that a failing economy, problems with agriculture, the deficit, unemployment, and taxation were all higher priorities than health care. Health care sat sixth despite ten years of haphazard cuts to the system, increasing waiting lists, and the elimination of the School Dental Plan.²⁴ People also appeared ready to shoulder health cuts if it meant restoration of the province's finances, improvements to the economy, and in the long run, improved health care. This became an important consideration for the Romanow government.

As a result, during the 1991 election Romanow's NDP campaigned on a platform of responsible government. Messages included a commitment to vision, sound leadership, and most importantly, a restoration of Saskatchewan's economic and fiscal health.²⁵ Furthermore Romanow vigorously cautioned voters that they should not have high expectations. Change was imminent due to the province's poor finances. He emphasized that people also needed to understand that health care had contributed to the poor fiscal state of the province, and so faced potential cuts too.²⁶ Once elected, his government intended to review the province's finances to determine the availability of resources to support existing programs and new initiatives.²⁷ Romanow also made clear his intentions to return the province to sound finances in his first term.²⁸

Romanow was true to his commitment. On December 2, 1991, two months after his landslide victory he established the Financial Management Review Commission (Gass Commission), with a mandate to review the province's financial situation.²⁹ In February

1992, Gass verified the province's 1991/91 budget deficit at \$975 million.³⁰ The public debt sat at \$12.07 billion;³¹ the highest per capita debt in the country. Without action the debt's continuing growth was imminent. Simply, Gass proclaimed the government's spending to be unsustainable. It had to be brought under control or else the province faced dire consequences.³²

Thus, in February 1992, Romanow's cabinet understood three facts: the public debt had risen from \$3.5 billion to approximately \$13 billion over ten years, and continued to grow; the province's credit rating was low, hampering future access to financial markets; and affordability threatened social programs and public services.³³ This knowledge led the cabinet to embark on an aggressive agenda focused on eliminating the deficit, promoting economic development, creating jobs, restructuring agricultural programs, and acting on health reform³⁴ – all in the first term. Fiscal pressures necessitated harsh action. It was the only way for the government to have enough money to manage its immediate expenditure problems and then to be able to implement a social democratic agenda in the future.

More importantly, Romanow's decision to include health care reform was self-evident. Health care spending represented approximately one-third of government expenditures and had grown faster than the province's GDP. Thus a significant part of the government's deficit and debt problem arose from its spending on the health system. Moreover, the economic realities of the day and the escalating costs of Saskatchewan's approach to health care challenged both the long term sustainability of the system and of the provision of care. At the same time, these growing expenditures failed to create a comparable improvement in the health of the population. In short, the dire fiscal and economic

circumstances ensured that health spending was targeted. Romanow noted, "...there are no sacred cows - even in Saskatchewan, the birthplace of Medicare."³⁵

Where the fiscal reality elevated the need for health reform, political necessity also justified health reform. The already mentioned reports condemned Saskatchewan's health system as inefficient and ineffective.³⁶ At the same time mountains of credible research supported viable options such as health promotion, population health,³⁷ and health determinants. In addition, almost all of Saskatchewan's health stakeholders supported these options as they both reduced costs and improved care.³⁸ Notably, some supported these options because they shifted the system away from the medical model and physician dominance.³⁹ The NDP too committed itself to these concepts and ideas when, in its 1989 submission to the Murray Commission, it spoke of them as alternatives that the NDP supported.⁴⁰

Furthermore, the NDP opposition created its own Pandora's Box. It relentlessly criticized Devine for failing to address the many problems in Saskatchewan's health system, and then proclaimed that once elected it intended to bring about the changes long sought after by health stakeholders.⁴¹ Moreover, the government used health change as a political tool. For example, in an effort to establish close relations with SUN, the NDP endorsed SUN's desire for changes to the health system. Hence, the implementation of health reform by the NDP government was understandable; it was in fact a political inevitability. The stage was therefore set for broad reform rather than just cost cutting.

The latter point was underpinned by the NDP government's philosophical foundations. The NDP, as descendants of Medicare's legacy, was then held up as Medicare's legitimate reformers.⁴² Simply, many stakeholders believed that in the hands of the NDP

government, health reform entailed a new policy direction that embraced the tenets of Douglas' second stage of Medicare and was not just meant to cut and slash.⁴³ It can be inferred that health stakeholders trusted reform in the hands of the NDP. They also believed, given their close relations, the NDP intended to protect stakeholder's interests and to involve them in the reform process. On the whole, this convergence of circumstances set the stage for moving the NDP government to health reform.

Health reform began in earnest with the November 1991 appointment of Louise Simard as Minister of Health, and then the installation in December of Duane Adams as Deputy Minister of Health.⁴⁴ Adams immediately formed the Wellness Team,⁴⁵ an internal group of officials from various departments knowledgeable about health policy. They were to do an extensive analysis on best practices in health delivery and then recommend a health reform strategy.⁴⁶ The team was expanded in January 1992 to include seventeen individuals from the health policy community as the government began to reach out to stakeholders.⁴⁷

At the same time, the government initiated a province-wide stakeholder and community engagement process. This extensive communications process targeted hundreds of people, organizations and communities, and aimed to educate them about the need for a reformed system and then the options available.⁴⁸ It also intended to gain input on, and to solicit participation in, the design of Wellness.⁴⁹ There were closed door meetings with SUN and the SMA, as well as with other stakeholders who held a view on health reform.⁵⁰ These discussions began the important stakeholder engagement process that set Saskatchewan apart from other provincial reform efforts.

In January 1992, for example, Adams spoke at the Saskatchewan Hospital Association meeting, providing numerous details on what a reformed health system looked

like. These details highlighted the extensiveness of reform. For example, the elimination of structural barriers and reorganization of the system, integration of services that included new ways of thinking and delivering services across the entire continuum, a focus on wellness models, the implementation of programming and structures to meet demonstrated needs throughout the province and the system, and restructuring of the bureaucracy.⁵¹ His speech emphasized to the group that the current financial situation forced these changes, many of which should have been made years ago.⁵² Lastly his comments underscored that these changes aimed to be collaborative however, the interests of the public, not those of a particular professional group, institution or program guided the government's decision making.⁵³ Thus, the government intended to implement reform with or without stakeholder support, and two factors – necessity and affordability – with the goal being to trim overall costs and redirect dollars to areas of need, were central.

Interestingly, while Adam's proposed these as formative conversations, his comments suggested that the government had already developed a plan for the design of Wellness. In fact, in February it publicly hinted at a staged reform process. As noted in an earlier chapter, the government spoke of stage one as creating the framework for the new system and included: system reorganization into the new health districts and new boards; establishment of the Health Services Utilization Research Commission (HSURC) and the Provincial Health Council (PHC); implementation of the new funding mechanisms; and the shifting of employees and services from the Department to districts.⁵⁴ Stage one ended with the election of board members who then took responsibility for their district's management and health services delivery.⁵⁵ At that point, the second stage commenced. It involved the shift to a broader, more integrated community-based and patient focused health system.

Establishing two independent arms-length organizations, HSURC (February 1992) and the PHC (announced in April 1992 but not operational until June 1993), early in the process, evidenced the government's strategic focus. Both offered third party empirical evidence on the problems within Saskatchewan's health system.⁵⁶ As well, both advocated for a range of public policies solutions necessary to improve the overall health system and health of Saskatchewan people and communities.⁵⁷ It was not a coincidence that the government and these organizations agreed on those policies. The government's recommendations were, like that of HSURC and the PHC, research based. Both instead, provided independent voices counterbalancing the expected resistance of health stakeholder.

Early in the process, the government also began working with key health boards on the formation of new health districts.⁵⁸ Saskatoon, Regina and Prince Albert all expressed interest in moving ahead with reform. Notably, each was already discussing amalgamation in their regions, though these discussions proceeded slowly. Institutional barriers and personalities impeded the process. In February, the Saskatoon Health Services Authority (SHSA) became the first health district under the yet to be unveiled Wellness.⁵⁹ The process went smoothly as the SHSA administrative leadership was very supportive of amalgamation. Previous studies on Saskatoon's health services validated the value of coming together.⁶⁰ Moreover, numerous services had been combined over the years. Thus reform completed the process and specifically merged the governance structure.⁶¹ In Regina, the health district structure arrived in April/May 1992,⁶² though the Regina Health District (RHD) did not formally establish until 1993.⁶³ The Regina board had already combined a number of services; reform simply completed the process.⁶⁴ In June 1992, Prince Albert established an interim Prince Albert Health Board.⁶⁵

One of the government's important contributions to these efforts was to encourage pre-emptive consultations with health stakeholders, health unions and the community. Consultations aimed to ease fears and frame reform as collaborative.⁶⁶ In addition, the government encouraged the local leaders to minimize the impact of the amalgamations on stakeholders. Simply, the government did not want stakeholder confrontations early before reform even began. As a result, prior to merging the SHSA engaged in extensive discussions with its unions and the community. In addition, the SHSA publicly committed early on to minimizing cuts by targeting administrative efficiencies and only making cuts to direct care as a last resort. Doing so eased possible tension with the unions and community.⁶⁷

While none of these boards formed under the Wellness model, and it is difficult to determine what role the government played in their decisions to amalgamate, each ultimately became an early example of Wellness' objectives. Hence, the work and then success of these boards proved important. Simard recognized and spoke of their efforts, noting their leadership in the creation of an improved and efficient health system.

Undoubtedly, underlying and conditioning these early reform efforts were discussions on the dire provincial finances. While the government had, and continued to forewarn people about the province's poor finances, the reality hit in the May 1992 provincial budget. That budget sent an ominous signal to the health system that the government was serious about stringently managing health expenditures. Budget day brought cuts of \$344 million across government and 500 jobs.⁶⁸ Health's budget was reduced by 3.51 percent, cutting expenditures by \$59.7 million from \$1.587 billion to \$1.541 billion.⁶⁹ Cuts included: a sizeable reduction to the drug plan; new fees for a number of health services; a five percent reduction in physician fees; and a 2.3 percent cut in hospital funding.⁷⁰ Cuts to hospitals

equated to a decrease of \$26 million. Some of the hospital funding was shifted to preventative and home based care.⁷¹ In addition, hospitals were put on notice of a further 3.2 percent cut in 1993/94.⁷² Even the new Saskatoon district faced a three percent or \$6 million cut, which became almost \$12 million with inflation and other increases considered.⁷³ A similar sized reduction was a reality for that districts 1993/94 budget. These were harsh announcements for Saskatchewan's health system. Health care would not be protected. It had to share in the restraint needed to bring fiscal health back to Saskatchewan.

Adams, Simard and Health Department officials resumed their efforts begun earlier in the year. They crisscrossed the province meeting with local communities, union leaders and the media selling the message about fiscal restraint and health system restructuring. People might support reform, the government believed, if they understood the problem. More importantly, the government worked to ensure people understood that the fiscal crisis was a reality underpinning health reform. Basically, these efforts prepared communities for the realities of reform. By summer's end, thousands of people had participated in these meetings.

The government's public engagement efforts culminated on August 17, 1992 with the release of A Saskatchewan Vision for Health: A Framework for Change – or Wellness.⁷⁴ Though many expected that A Saskatchewan Vision for Health should offer a definitive direction and plan for Saskatchewan's health reform, it was restricted to a "...conceptual framework for major reform and revitalization of the Saskatchewan Health system."⁷⁵ The document intended only to guide reform. As a result, many felt significant disappointment. They wanted the government to dictate the process.

In this regard, the government was tactical. In offering only a vision and vague goals, A Saskatchewan Vision for Health avoided becoming a target. Indeed, no one could disagree

with the vision of a better health system, or with having health promotion, education, prevention and wellness as central goals of Saskatchewan's health services.⁷⁶ More importantly, the document stressed that the government did not want to shape health reform nor did it want to run health care.⁷⁷ Reform was a community exercise. Strategically, this focused attention on public participation and ownership of the system's transformation, preempting potential early stakeholder resistance.

Yet, the document also clearly signalled significant change. Integration and coordination evolved from regionalization, rationalization, and restructuring. Community focused delivery meant local control and accountability.⁷⁸ A better use of health resources meant new roles for health professionals, changed roles for physicians, and an emphasis on sustainability, qualitative measurement and cost containment.⁷⁹ Communities were to form planning committees to perform needs-assessments and begin creating larger health districts. Physicians and the government were to identify potential alternative funding mechanisms. Together, these were the central components of Saskatchewan's health reform effort. Of course, the document also aligned reform with improving not only the fiscal wellbeing of the health system, but of the province as well.

Thus, from the start A Saskatchewan Vision for Health set out to gain public and health stakeholder's buy-in while also appeasing their concerns. Past attempts at imposing change on Saskatchewan's health system resulted in vociferous resistance. Conversely, the Murray Commission evidenced that Saskatchewan's health stakeholders willingly engaged in discussions on changing the health system and could even be supportive if they believed the change was positive and they could be part of the process. The government's plan succeeded. At the unveiling of the A Saskatchewan Vision for Health, representatives from

SUN, the College of Physician and Surgeons and the Regina Community Clinic, participated alongside Simard. Others responded positively and with the same bluntness as Hewitt Helmsing, director of the Saskatchewan Health Care Association, who publicly stated that Wellness was long overdue.⁸⁰ These stakeholders both supported and set out to participate in the reform process. They seemingly did so because they believed in the opportunities offered by the nascent reform, and because they wanted to be involved in shaping reform.

Wellness' design also tried to lessen the negative response from rural communities. Rural people were, since past reports and studies had recommended rural hospital closures, understandably suspicious of reform. Thus, there was no surprise when alarm was raised. For example, the Mayor of Climax warned that "...if the government ever decided to close Climax Border Union Hospital...It would be a disaster for us..."⁸¹ Kyle Mayor Ansgar Tynning echoed the warning, noting that "These people need assurances a doctor will be there."⁸² Fortunately for the government, an important rural ally appeared. The Saskatchewan Association of Rural Municipalities (SARM) indicated optimism over the changes and looked forward to working with the government to implement them.⁸³ Hence, to the government's satisfaction, initial rural response to A Saskatchewan Vision for Health turned out to be positive, though cautious.

With A Saskatchewan Vision for Health unveiled the government moved to another large communications process. Sizeable meetings occurred in August and October 1992, along with two major regional consultation tours, one in September 1992 and the other in December 1992.⁸⁴ At each meeting the messages spoke of the value of reform and Wellness. Of course, the other primary message focused on how finances left the government no choice; that reform was about protecting Saskatchewan's health system. Notably, the

government also quickly rejected calls by the opposition for public hearings on health reform.⁸⁵ It argued that since this was a community based process it wanted to engage people at the community by community level.⁸⁶ Yet, a more appropriate explanation is that public hearings shifted control of the process away from the government, it reduced personal contact with communities and stakeholders, and it was very public process. All were valid reasons for the government to avoid hearings.

In rural areas, the government tried to sell them on the value of reform for their communities. Simply, reform provided them with better quality health care. Though some services might leave their local town, these redirected resources supported additional services, programs, physicians and health professionals in larger, better equipped health centres in a nearby community.⁸⁷ Moreover, under reform rural communities owned these health services. Thus they had an opportunity to shape key delivery decisions through their planning committees and their new (and soon to be elected) health boards.⁸⁸ By getting involved local people could take advantage of Wellness' opportunities in their community. At the same time, the government also worked hard to dispel rural views that health reform was "...merely to cut costs,"⁸⁹ and surreptitiously about closing rural hospitals. This was a challenging paradox. In essence, reform would close or alter health services in a town, and it was clearly tied to affordability. However, the government hoped the resulting system stood as a better alternative. Hence, even as rural people grasped the necessity and even the possibility, they remained leery. Yet, they agreed to participate in the process since they felt assured by the government's commitment to community ownership, though, some for no other reason than to protect their communities. They understood the inevitability of reform.

Likewise, the government focused on management of organized labour. As a result, from the start it was both attentive to labour's response and actively encouraged labour to be part of every aspect of Wellness.⁹⁰ Fortunately for the government organized labour also wanted to be part of the process.⁹¹ As already noted, health workers readily supported a realignment of Saskatchewan's health system, frustrated by the system's inefficiencies and waste, which contributed to poor and misaligned care.⁹² As well, labour was supportive of a focus on prevention, population health and health promotion, irritated at having to care for preventable health problems.⁹³ It had also been party to a plethora of shelved reports and commissions, such as the Murray Commission, which documented their concerns and the system's problems. Wellness was an exciting alternative to existing paradigms.

In addition, reform opened the door to fixing Saskatchewan's outdated health sector collective bargaining structure. Littered with 25 collective agreements, 382 locals and 538 bargaining units, and every work place subject to different rules, the structure was unwieldy and dysfunctional.⁹⁴ Management, the government and even unions were extremely frustrated.⁹⁵ Past governments had avoided tackling the problems, even after various reports had recommended fixing Saskatchewan's unhealthy labour environment.⁹⁶ Unions even turned to the Saskatchewan Labour Relations Board (LRB), though that too ended in failure.⁹⁷ All involved, and particularly the government, understood that because of intense union rivalries, power struggles and protectionism, finding a remedy would be difficult, while imposing one meant political suicide.⁹⁸ Thus, health reform became an opportunity for both the government and its union stakeholders.

Yet, labour also worried about health reform. It held out potential for job losses, instability and even raiding by other unions. They did not enter reform willingly but did so

because they understood they had no choice – the fiscal crisis was evident. They also moved to reform because they believed that the government intended to consider and even protect union interest.

The NDP government's solution was to involve labour in the process. Inviting labour ensured a collaborative rather than antagonistic reform process and more importantly, built on long standing NDP-labour relationships. Hence, from the beginning, labour was invited onto local planning committees and conversely, planning committees were encouraged to consult with local union representatives.⁹⁹ There was also an open door policy that allowed union leaders regular contact with the government. Ultimately, these were important strategic steps in ensuring labour's commitment to Wellness.

Unfortunately, Simard's community meeting schedule and administrative work load meant that she had little time to dedicate to organized labour groups. In September Lorne Calvert was appointed Associate Minister of Health, an action heralded as an example of the government directing attention to labour's concerns. Calvert was charged with the sole responsibility for overseeing the labour component of health reform. One of his first actions was to execute the commitment in A Saskatchewan Vision for Health to a formalized labour engagement process.¹⁰⁰

In December the Labour Relations Review Committee (LRRC) was established,¹⁰¹ and tasked with making recommendations for changes and new approaches to employee relations in the health sector.¹⁰² From December to March 1993, the LRRC met with bargaining units, newly formed health boards, Department of Health officials, Saskatchewan's labour community, and groups outside the province.¹⁰³ Unfortunately, the LRRC did not achieve the desired results. Early on an impatient government undermined the

committee's and credibility work by forging ahead with the formation of a 'common table' bargaining structure,¹⁰⁴ and then, by introducing the *Health Districts Act* in the Legislative Assembly in March 1993. In both instances, the LRRC's input was not solicited.¹⁰⁵ Then the LRRC leadership divided, creating two reports and recommended directions to government. Neither provided workable solutions. With the failure of the LRRC, one of the government's key efforts, establishing labour's leadership of the restructuring of health sector collective bargaining, failed.¹⁰⁶ Indeed, the LRRC simply laid this responsibility at the feet of the government.¹⁰⁷ Though the LRRC was a disappointment, it did provide important affirmation of labour's support for reform and of labour's willingness to attack collective bargaining issues.¹⁰⁸

During these early months, the government paid close attention to the views of SUN. As noted, Simard and SUN had already established friendly relations and this alliance was influential in setting Simard's approach to Wellness and in convincing Simard that reform was possible. More importantly, SUN was a powerful, militant and outspoken union that held a great deal of credibility with the general public. If SUN and nurses supported health reform, chances of reform's success were even greater.

Understandably, SUN's approach to reform was pragmatic: reform needed to reflect nurses' issues.¹⁰⁹ Over the years nurses had grown frustrated by a system that remained unchanged and unresponsive to patient needs and, equally, to nurses' needs. For example, nurses wanted to work less hours, reduced workloads and increased wages. Vacancies grew across the system, as did their workplace stress.¹¹⁰ In a more general sense, they sought more influence, increased career opportunities, widened responsibilities and new levels of autonomy and authority based on their central role in patient care.¹¹¹ In addition, as nurses

grew frustrated by what they saw as a system failing to provide the best and most efficient care, they supported shifting to primary health care with its focus on public health, prevention, education, promotion, screening and monitoring.¹¹² Notably, SUN endorsed the Murray Commission's recommendations, and in particular, those that recommended changes to nursing services to reflect increased professional responsibilities and new circumstances.¹¹³ Likewise, Simard endorsed SUN's issues and solutions during her years in opposition. As a result, nurses responded positively to reform, and in particular, to reform's attention to nurses' concerns. Thus, the longer term benefits of reform were worth the short term pain. Already the 1992 provincial budget cut nurse's jobs and meant more work.¹¹⁴ SUN responded by encouraging nurses to bear the pain.

Simard's positive support for SUN's issues, alongside her longstanding relationship with SUN, was also critical. In fact, it was probably central in leading SUN to quickly ally with the government. This alliance provided them a means to both protect and advance nursing interests. The Saskatchewan Registered Nurses Association (SRNA) applauded the relationship commenting that "Meetings between SRNA and SUN at the provincial level have been very exciting and encouraging... Continued discussions of this nature can only result in benefits for individual nurses"¹¹⁵ Ultimately, the close relations and insider's view aided in their belief that reform offered nurses many benefits. If these benefits disappeared, so too would their support.

The close relationship with Simard likely also played a role in convincing SUN that the fiscal crisis was real and that the government intended to move forward with health reform regardless of SUN's views – the fiscal crisis ensured that. Participating in the process brought more benefits than did resistance.

SUN also remained leery, though. Over the years past governments had failed to address nurses' needs, in their view, largely because each had catered to physicians.¹¹⁶ Thus SUN noted its support was conditioned on the government having the "...courage to go beyond cost cutting in acute care, and actually tackle the bloated fee-for-service system, that is the biggest obstacle to genuine reform...."¹¹⁷ In fact SUN stated it remained vigilant and ready to criticize the government if it saw otherwise.¹¹⁸ True to their word, through the early months of 1992, SUN pushed the government aggressively on nurses' issues.¹¹⁹

Other explanations exist for SUN's early support for reform. SUN's interest in reform likely also arose because of the government's intention to change Saskatchewan's health sector bargaining environment. As SUN, CUPE and SGEU represented nurses and engaged in an acrimonious rivalry over members and issues, SUN sought to be involved to not only ensure its interests were protected, but to possibly to gain members from other unions. SUN also hoped for an improved bargaining environment.

Furthermore, nurses were weary, still reeling from the acrimonious eleven day May 1991 strike that had followed on the heels of a similarly difficult strike in 1988. One SUN member noted, "I love nursing, but I can't tolerate the stress of striking every two years...there must be a better way."¹²⁰ These strikes caused a sizeable operating deficit for the union and created pressure for increased dues and internal fiscal restraint; neither was welcomed by members.¹²¹ SUN's leaders were also fatigued. President Pat Stuart resigned in early 1992, citing the pressures of a number of difficult years at the helm. An interim President was appointed to replace her. SUN, too was exhausted by years of poor relations with the Conservative government. Thus, the union looked forward to working collegially with an NDP government with whom it had a history of positive relations. It was a

collegiality that was reciprocated as SUN had easy access to the offices of the government and was part of almost every committee.

The government considered physicians the other important stakeholder in the reform process. Yet, an entirely different relationship existed between this stakeholder and the government. As already noted in the earlier chapter, their relationship in recent years had been respectful, yet an underlying tension existed. Simply, physicians' remained ever fearful of attempts by the government to erode their position within Saskatchewan's health system.¹²² On the whole, these included attacks on physician autonomy, efforts to control physician's scope of work and attempts to implement alternative payment schemes. For this reason, every government-physician discussion contained unspoken threats that physicians were willingness to resort to aggressive resistance. As a result, every previous Saskatchewan government stepped back from these policy directions.

Yet, reform undeniably intended to address physician-related issues.¹²³ The government had no option. Physicians were a major cost driver in Saskatchewan's health system and they historically stood in the way of meaningful system transformations. A Saskatchewan Vision for Health unmistakably identified the reshaping of physicians' roles in the health system. Moreover, Simard acknowledged that her far reaching health reform agenda was achievable only if physicians participated.¹²⁴ Thus, as reform of physician services was essential to the government's plans, management of physicians was a key priority. Moreover, for the sake of other stakeholders, physicians could not escape the pain.

There were two reasons why the government was confident that Saskatchewan's physicians could be convinced to participate in Wellness. In spite of physicians' credibility, the government made it clear that the province's fiscal crisis meant that a refusal to join in

restraint exposed physicians and their Association, the SMA, to public criticism. In particular, physicians could expect the criticism to focus on the costs of their fee-for-service remuneration. Additionally, the government believed that physician concerns could be eased if they, and the SMA, were invited to participate in health reform and to understand its benefits.¹²⁵

The government thus initiated a collaborative engagement process.¹²⁶ It was a process that began in early 1992, and before the unveiling of Wellness.¹²⁷ Early meetings with the SMA apprised them of reform's intent and directions and the discussions honed in on the benefits of reform for physicians, such as the removal of barriers to patient care and opening up of new practice opportunities.¹²⁸ Participation on community planning committees and other working groups was also encouraged. An important message and early compromise occurred when the government assured the SMA that, although alternative payment schemes were being explored, it would not force physicians to join.¹²⁹ Interestingly, this contrasted with the fact that Department staff had been assigned to study, develop and implement policies for moving physicians to alternative payment methods.¹³⁰ Clearly, the government was prepared to maintain peace with physicians while furtively moving a physician reform agenda forward.

As a result, physicians offered cautious support for reform.¹³¹ The College of Physicians and Surgeons suggested that it believed there was value in Wellness.¹³² Reform could improve health services to patients, it could offer healthier environments for physicians, and it could bring more physicians into rural Saskatchewan. More importantly, reorganization and regionalization gave no hints that physicians traditional methods and practices would change, or rather, that the government intended to impose unwelcome

change upon physicians. Nonetheless, some individual physicians held mixed views on Wellness fearful of potential attacks on their remuneration and autonomy, of hospital closures in their communities, of reduced funding, and of increased workloads.

More importantly, physicians also understood the gravity of the fiscal crisis. Not only had the 1992/93 budget cut health expenditures, it cut funding for physician remuneration. In making these cuts, the government proclaimed that over the previous four years physician fees had increased by 3.4 percent annually despite a drop in Saskatchewan's population.¹³³ Indeed, the government's announcement on the matter noted that "...one major key to controlling cost growth in health care is achieving controlling of open-ended programs like physician services...."¹³⁴ For physicians, the message was clear. Interestingly, however, the service agreement signed in November implemented only a 2.4 percent reduction, though it did insert cost control mechanisms that included a restriction on service coverage, restrictions on the number of non-resident physicians and a soft capping mechanism that penalized physicians who encouraged excess utilization of their services.¹³⁵ The agreement also committed both sides to the development of a longer-term physician resource strategy.¹³⁶ While the government promoted the agreement as incenting physicians away from fee-for-service and onto alternative remuneration methods, and controlling costs, it once again demonstrated the government's unwillingness to strong-arm its physicians. Even SUN observed that the agreement did not going far enough to contain physicians' costs.¹³⁷ More importantly, SUN believed it failed to move physicians away from fee-for-service remuneration.¹³⁸ Interestingly, the SMA commented that the poor financial state of the province significantly influenced their discussions to support the agreement.¹³⁹

By December 1992, the government found it had weathered the first few months of reform successfully. The media responded positively to the A Saskatchewan Vision for Health. The messaging around reform achieved its goals as a poll that month found 72 percent of the respondents supporting the conversion of small rural hospitals to other health care uses,¹⁴⁰ and, 50.6 percent agreeing that the government should emphasize preventative care even if it meant cutting hospitals to achieve this goal.¹⁴¹

Thus, by the end of 1992, the government's first steps towards health reform proved fruitful. A Saskatchewan Vision for Health received initial cautious support from all of its stakeholders.¹⁴² Physicians expressed limited concern, while other health workers, and especially SUN, were generally supportive.¹⁴³ Simard's extensive travels across the province promoting Wellness and encouraging public and stakeholder involvement earned the support of people in rural Saskatchewan. Though fearful of hospital closures and other negative ramifications, they remained willing to participate. Thirty-five community planning committees – the number Simard recommended - analyzed local health needs and drew the new boundaries for their district; a task which was to be completed by August 17, 1993. Hospital administrators, home care staff, public health nurses, physicians and local people actively participated in the processes.

While stakeholders, for the most part, supported reform, the government also acknowledged that each came to the process, not because they fully endorsed reform, but rather because a fiscal crisis marshalled them along. Moreover, each had as a key objective the protection of their constituents. The government's communications and messages successfully convinced stakeholders of the value of reform in that regard, while reinforcing the underlying fiscal imperative. Thus the public and the media were on side, and as a result

stakeholders were on board. The government's health reform agenda had taken hold and for the most part, in its first year, could be labelled an initial success.

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¹⁴ *Ibid.*, 79 – 80.

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²¹ Terry Craig, "Health Care Proposal 'Real Slap' to Small Town," Saskatoon Star Phoenix May 2 1990, A5.

²² Peter WB Phillips, "Whither Saskatchewan? A Look at Economic Policies 1975-2000," Canadian Business Economics 6 (4) Nov 1998, 39.

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²⁶ Brent Lannan, "The Tarnished Brass Ring," Sask Report Vol. 7 (6) November 1991, 9. pg 7-10

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²⁸ "Something Can Be Done," The Commonwealth 50 (4) September 1990, 13.

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³⁰ *Ibid.* 27. At October 31, 1991 Gass stated the deficit was \$1.15 billion.

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Chapter 3: The Middle of Health Reform: Bearing through the Pain

1993 and 1994 were pivotal years for reform. Over the course of these two years, reform moved from the nebulous state of A Vision for Health Care, into a concrete reality. Not only did the actualization of reform begin – rationalization and reorganization – but a tough 1993 provincial budget and deficit/debt reduction plan implemented immediate cuts, closed rural hospitals, and imposed longer term health spending restraint. Never before had Saskatchewan’s health sector experienced such large cuts and extensive change. As expected, the significant outpouring of stakeholders anguish and anger filled newspapers and airwaves, and spilled over into coffee rows across the province.

Only the fiscal crisis held both stakeholders and the government alike to this tough reform agenda. Yet, more was required to end outright conflict. Hence, the management of health stakeholders became a central concern for the government. It turned to a number of different tactics, such as creating committees, entering into discussions and educating stakeholders, to pacify and persuade. Importantly, the government also turned to small monetary and non monetary concessions when these tactics failed. While this enabled reform to stay on track, it also began the grinding down of reform. Simply, the pattern was set. As the “pain” of health reform hurt stakeholders’ members, they in turn became critical of reform, the press coverage worsened and the public grew concerned. The cycle began anew. Hence, though these concessions slowed stakeholder criticisms and resistance, they ultimately became its failure. Thus 1993 and 1994 is the story of how the government tried to pursue A Vision for Health Care in the face of vast stakeholder resistance. It discusses why that resistance led the government to choose one tactic over another, and more importantly, to use concessions, in due course began the slow unwinding Wellness.

The framework for 1993 was set by Janice MacKinnon, the new Minister of Finance, who signaled alarm over the state of Saskatchewan's finances. A deep recession settled upon Canada,¹ hitting Saskatchewan particularly hard.² National and provincial unemployment levels were significant.³ No relief was anticipated for 1993. Even more problematic, the provincial government missed its 1992 budget target, increasing total debt to \$14.7 billion; the worst per capita in Canada.⁴ Cuts to federal transfers for health and education added to the province's woes. Even with projected economic growth in 1993, Saskatchewan anticipated an increasing budget deficit and debt.⁵ Credit rating agencies began to signal their intention to lower the province's credit rating; one major agency even characterized Saskatchewan's fiscal state as a crisis.⁶ The province teetered on the brink of bankruptcy. The government had to act.⁷

While fiscal issues pressured the government, local health planning committees also began to feel pressure. In January they received the Health Needs Assessment Guide for Saskatchewan Health Districts.⁸ It detailed the proposed formulaic needs-based approach to be used in crafting the new services and programs for future health districts.⁹ While sensible, this new approach differed vastly from the previous system.¹⁰ Responsibility for identifying and developing health programs and services for local communities shifted from Regina bureaucrats to district planning committees.¹¹ These committees now carried a huge burden. New programs identified as meeting the health needs of the community, replaced existing, even long standing low-value ones.¹² Moreover, these services and programs were typically relocated to a larger centre in the district in order to take advantage of economies of scale. At the same time, the province's fiscal state meant planning committees also had less funding to work with.

Rural communities, more so than urban, faced change. Within a rural district, some towns gained, while others, typically the smaller, lost. While this meant many longstanding health programs and services ended, it also ended the accompanying jobs that provided employment to small town Saskatchewan. In essence, many saw reform as killing rural towns.¹³ Madonna Unterreiner, the Chief Executive Officer and Director of nursing at Bengough hospital noted as much when she said that needs assessments was “....designed to start squeezing the fiscal life out of rural hospitals....”¹⁴

While annoyed, outright resistance to these changes was muted by MacKinnon’s March 18, 1993 budget which centred the government’s agenda on fiscal management.¹⁵ Importantly, the budget’s Balancing the Budget -- The Fiscal Plan included a target of balancing the provincial budget by 1996/97.¹⁶ The plan aggressively reduced spending across government – public sector jobs, programs and services were rationalized or cut¹⁷ – and taxes were increased. Overall government operating expenditures dropped 3.4 percent for the year.¹⁸ Cuts were also announced for the 1994/95 fiscal year.¹⁹

Health care spending fell too, with an overall reduction of 3.0 percent.²⁰ Cuts hit three areas of spending. The children’s publicly funded dental plan was eliminated. The prescription drug plan was redesigned. Hospital budgets were reduced by 3.0 percent for 1993/94,²¹ with \$18.5 million cut from hospital operations and \$2.5 million from special care homes.²² Health capital also fell \$7 million.²³

Budget day Simard also announced the new *Health Institution Strategy*. The strategy’s goals were straightforward:

- A shifting of resources from institutions to community-based services such as home care;
- A reduction of approximately one third in the number of acute care beds and a redistribution by location and function;

- A targeted reduction in the number of long term care beds and the phasing out of funding for “light care”; and
- The conversion of hospitals to community-based care facilities without acute care.²⁴

In essence, the government reduced its support for acute care services via targeted reductions in funding – rural hospitals at 5.5 percent, base hospitals at 3 percent and regional hospitals at 2 percent²⁵ – and by mandating a lower level of total number of acute care beds. A further reduction of 2.8 percent to acute care funding was identified for 1994/95.²⁶

The implication of these decisions was clear. There would be program cuts and beds closed across Saskatchewan. Indeed, in making the announcement Simard noted that three facilities bore the brunt of the cuts: Melfort, Swift Current and Weyburn.²⁷ Within weeks the Weyburn Regional Health Centre, cut 10 percent or 50 of its 500 jobs,²⁸ with the others following soon after.

From that moment on, Wellness became less about improved health care and more about funding cuts, especially to health facilities and services in rural Saskatchewan. A few weeks earlier the introduction of the *Health Districts Act* garnered little criticism from stakeholders, likely since the act was administrative in nature. It defined the framework for health district boards, the responsibilities of each board and the election process.²⁹ However, following the budget and health cuts, the debate on the *Health District Act* provided a forum for attack on health reform, and in particular, cuts. Not only did rural communities provide the opposition with stories about lost beds and jobs, numerous rural towns and communities signed opposition petitions asking for funding to be restored. As a result, the Legislature resounded with heated and emotional exchanges, almost all of which were covered by an attentive media. Understandably, public interest swelled, especially as the opposition clamored to defend rural Saskatchewan. The opposition raised the specter that rural towns,

not urban centres, had been handed an unfair share of the cuts,³⁰ and that these hospital and bed closures meant the end of rural life.³¹

Moreover, rural communities also acted. Politicians received irate letters.³² People complained in the media. Public meetings also began across the province. Over 300 people attended a March 29th rally in Prince Albert organized by the newly formed Concerned Citizens for Health Care;³³ in late March 500 people attended a meeting in Leader;³⁴ on April 1st another 500 people gathered at a meeting in Eatonia;³⁵ and almost a week later 500 met Simard in Weyburn.³⁶ In Melfort 35 people stormed the annual NDP meeting of the Minister of Community Services.³⁷ In a matter of weeks, hundreds of people attended numerous meetings protesting reform's cuts. Even more meetings were scheduled.³⁸ In essence, rural communities across Saskatchewan were not about to accept these cuts and changes.

While the government felt concern over rural Saskatchewan's response to reform, it was even more worried by labours'. SEIU SGEU and CUPE joined some of these protests and rallies. CUPE even designed a button that said, 'Without Workers Wellness Won't Work'. Their workers attacked the government stating "...we're not losing our jobs – we're losing our professions..."³⁹ These unions represented the concerns of those employees facing layoffs and worried about finding new work.⁴⁰

On April 6, 1993 the government had enough of the oppositions delaying tactics, and introduced closure. Appreciating the potential for a negative reaction to closure, Simard's speech that day tried to defend reform's cuts as imperative – the outcome of a fiscal crisis – and closure as stopping the boondoggling of an opposition who firstly created the fiscal and health system problems, and now attempted to prevent the work of community planning committees who supported reform and who worked hard to make it happen.⁴¹ Nonetheless,

closure simply ignited another vigorous opposition response, and unfortunately, even more negative media coverage.⁴²

The closure motion, ostensibly, arose in direct response to the escalating emotional debate in the Legislature and media. And, though in and of itself, it resulted in more debate, the public attack on reform had to end. Continued debate increased the potential that the wave of protests could expand. Yet, the government also legitimately needed to expedite the reform process. Significant support existed across the province and amongst health stakeholders. Even as unions and organizations, like the Saskatchewan Public Health Association, raised concerns about reform,⁴³ they continued to publicly endorse Wellness' goals and principles. Many communities were moving forward in their work. Moreover, polling confirmed that the public supported health reform. During the worst of the public rallies, a government poll showed that 52 percent of the population supported establishing health districts,⁴⁴ and support for reducing hospital beds hovered around 53 percent.⁴⁵ These results mirrored those of a December 1992 poll. Both polls confirmed for the government that the majority of the public agreed with health reform and solidified the government's commitment to pursuing reform despite the protests.

Furthermore, planning committees who were ready to form their health district and health board required a legislative framework. Thus the *Health District Act* legislation needed to be passed. Delays only contributed to instability. While a mixture of approaches had already been used⁴⁶ – the *Crown Corporations Act* the *Non-Profit Corporations Act* – some pressed the government. For example, the Saskatchewan Health Care Association (SHCA) stated that “Many areas are ready to form their district and it's essential that the right legal framework be in place to enable them to do so.”⁴⁷ The government could not allow the

process to be bogged down in bureaucracy, which in turn might erode the support of these planning committees. Ironically, even the opposition condemned the government for not having passed the legislation, noting that this caused problematic delays for boards.⁴⁸

Unfortunately, the government's reform agenda was severely altered on April 14, 1993 when reform took on a new dimension. On that day – later known as “Black Wednesday”⁴⁹ – the government closed or converted 40 percent of the province's 132 hospitals and integrated care facilities. Over half (28) were to be completed by October 1993 and the rest (24) by early 1994. The same day, Regina's Health Board announced the closure of the Plains Health Centre.⁵⁰

Although the government emphasized that the decision to close hospitals was motivated by “...the fiscal crisis that faces our province,”⁵¹ other reasons existed. A key reason was that the budget a month earlier clearly signaled the inevitability of hospital closures. The government, therefore, simply took responsibility for a difficult decision, relieving health boards of a task that could entangle them in antagonism and impede their future relations with community members and health stakeholders.⁵² One board member noted as much suggesting his board “...wanted the government to close hospital beds because there was fear that no one would run for the district board if bed closure decisions were made locally.”⁵³ Moreover, closing all the hospitals at once coordinated the rationalization process and sped up reform.⁵⁴ Thus, the pain from waiting for each individual health board to finish their planning process was avoided.

In addition, this approach placed the government in front of reform's message. Twenty-three integrated facilities did not close, but instead received funding for long-term care operations. They also received an additional \$42,500 per bed to help find alternatives to

acute care delivery, such as, the creation of a wellness centre to house emergency acute care and other health care programming.⁵⁵ This message was important, and one that the government needed to highlight: closure of a hospital did not mean the end of health care in a community.⁵⁶ Unfortunately it was a message soon drowned out.

The government also felt confident in its policy direction. On the whole, closing hospitals was not without support. A reporter noted, "...the NDP only did what is necessary and something that should have been started much earlier...now will be the time to pioneer a new, leaner system that reflects today's changing financial conditions...."⁵⁷ Even some rural newspapers, like the Fort Qu'Appelle Times, promoted the value of closures:

. . . while one cannot underestimate the economic blow the hospital closures meant to these communities, neither can one deny the fact that the Romanow government's complete restructuring of the province's health care system was necessary. This province can no longer afford to keep hundreds of hospital beds open across the province when only a very small percentage of them were in use at any one time. The millions of dollars that were being spent on these facilities can obviously be used more effectively and wisely in other areas of our health care system.⁵⁸

Likewise, other supporters included the Saskatchewan Association of Special Care Homes, the Prince Albert Health Board, and the Saskatchewan Registered Nurses' Association.⁵⁹ Quietly, SUN too supported this action. Even the College of Physicians and Surgeons wrote in a letter to Simard that "We do our rural citizens a grave disservice if we continue to support and foster the idea that maintenance of a hospital in their community is the only basis for assuring high-quality accessible health care. That is...frankly, dishonest."⁶⁰

Nonetheless, affected rural communities and people opposed to reform reacted negatively. They complained in the media, or contacted their MLA or the Minister of Health. Simard and Calvert received an extraordinary amount of mail, reaching 250 to 300 pieces in the months following.⁶¹ Rallies began anew across the province.⁶² A public rally at the

Legislature on April 21, 1993 brought out 800 angry protestors. During that rally protestors carried placards proclaiming: "The New Death Plan: Rural Hospitals; Not Coffins" or "Rural bumpkins need acute-care beds, too!" and "Wellness is killing rural Saskatchewan."⁶³ The crowd booed Simard when she came out of the Legislature to speak to them.⁶⁴ Rural people were so angry that in one instance NDP MLA Glen McPherson needed an RCMP escort out of a community he was visiting.⁶⁵

The message was clear: rural people felt deceived. Reform came to represent betrayal and duplicity by the government. Rural communities had been told that reform was not about closures, yet it was. Moreover, closing hospitals had undermined the government's promise of letting community's shape their health reform.⁶⁶ Communities also linked hospital closures and health reform to the fiscal crisis; reform was about saving money, not improving health care. At its worst, reform became characterized as "...hellness and wealth reform...."⁶⁷ Reform also converged with other government imposed actions: school closures and the cancelling of the popular agriculture support program, GRIP (Gross Revenue Insurance Plan). Hence, health reform became part of "Romanow's Rural Revenge."⁶⁸

The government countered with a simple strategy. Cabinet Ministers and department officials travelled rural Saskatchewan attending many intense and emotional community meetings.⁶⁹ Even the Premier faced angry crowds.⁷⁰ Through it all government members took responsibility for and defended their decision.⁷¹ The message was direct: health reform offered better and efficient health care, and the province's finances made reform an imperative.

Understandably, the government grew concerned with the number of rallies, the level of anger and the potential for both to erode the support for reform by the general population and health stakeholders. In response, the Rural Health Advisory Committee (RHAC) was created in May.⁷² It was to identify health care issues in rural communities and assist the government find solutions by making suggestions to ease the transition process in rural Saskatchewan.⁷³ With the committee in place, the government hoped many of the rural issues could be resolved, or at least mitigated.

Similarly, the government looked to alleviate labours' unease with reform's changes. While rural communities carried some influence on the fate of reform, the government simply could not keep reform afloat if it lost labour's support at the same time as rural Saskatchewan grew angrier. In particular, a red flag emerged in March when SUN and CUPE presented a brief to the Minister of Health. It highlighted concerns with Wellness. The brief noted that reform was moving too quickly and lacked adequate planning. As well, it reiterated demands for the transformative shift of Saskatchewan's health system promised in A Vision for Health Care.⁷⁴

The government responded to what they viewed as the more important of these concerns by creating the Health Reform Labour Transition Coordinating Committee (HRLTCC) in April. The HRLTCC became the government's proactive strategy for addressing worker displacement and easing labour concerns over reform. The committee brought together health sector unions (SUN, SEIU, HSAS, CUPE and SGEU), employer representative groups, representatives of the newly created district boards, and other non-organized groups within the health care system to examine "...strategies for minimizing the impact of health reform initiatives and budget cuts on health sector employees."⁷⁵ Sub

committees were also used to consider matters like transfer agreements and employee career adjustment support to assist with transitioning to new opportunities in the reformed health system.⁷⁶ Health boards and district planning groups were asked to support the work of the HRLTCC by proactively identifying the number of people affected by layoffs and working to channel these people to other areas.⁷⁷ As a result of its work, the HRLTCC created two new programs: a two year Health Reform Transition Program (H RTP) to assist health care workers affected by health system changes,⁷⁸ and the Career Adjustment Assistance Program (CAAP), to mitigate the impact of health reform on employees by assisting with career transition including job postings services, financial support for training, and relocation. A joint union-management committee oversaw the CAAP and government provided \$3.4 million or up to \$5,000 per employee for redeployment and severance.⁷⁹ These programs were initially effective in easing labour concerns over health reform.

More importantly, the government adopted a committee resolution process for labour stakeholders as it had with rural communities. However, in the case of labour, the government anted up funds to facilitate the work, and thus keep labour on side. While small in size, these funds highlighted to all that money could be found to ease stakeholder pain.

At the same time, the government also pressed forward with reshaping the health sector collective bargaining structure. In part due to the urging of the government, SUN, SEIU, CUPE and SGEU came together under the Council of Health Unions in 1993 to work on jurisdictional issues, employee mobility, transition issues and bargaining structures.⁸⁰ Though they willingly worked together on a number of these issues, they reached an impasse on the restructuring of Saskatchewan`s health sector bargaining. Competing interests could not be set aside. The government, though disappointed by this failure, resisted forcing a

solution upon health unions. In the early 1990s, the previous Conservative government's effort in this regard, resulted in a negative and vociferous labour response, and thus a quick retreat.⁸¹ This government did not intend to ruin its relations with health care unions over this matter, or more importantly, to create a reason for labour to unite against health reform. Instead, it opted to take a patient approach by letting labour find its own solutions. This also meant collective bargaining reform, an important component of reform, remained on the back burner.

On the employer side, the government initiated discussions on the merger of the three health care employer associations - the Saskatchewan Health Care Association (SHA) responsible for collective bargaining in the hospital sector, the Saskatchewan Association of Special Care Homes (SASCH) responsible for collective bargaining in the special care homes, and the Saskatchewan Home Care Association (SHCA) responsible for collective bargaining in the home care sector.⁸² By July 1, 1993, an agreement was achieved and the three merged, forming the Saskatchewan Association of Health Organizations (SAHO), and creating a single employer voice in the province. The merger was a step towards increasing efficiency within the health system and resolving long-standing employer related problems within Saskatchewan's labour environment. A single employer ensured a coordinated voice at the bargaining table. Moreover, this approach harmonized the employer's responses to workplace problems created by health reform.⁸³

Interestingly, the government was strategic in its approach to working with individual health stakeholders. As noted already, SUN garnered the most attention. Through 1993, the government acknowledged that SUN members bore the brunt of many of the changes. Indeed, some initial job loss estimates suggested that as many as 700 nursing jobs

disappeared due to hospital closures and conversions. The government scaled up efforts to maintain regular contact and dialogue with the union. These sessions enabled SUN to raise issues about reform behind closed doors.⁸⁴ SUN was also invited to participate in district planning committees, and health district boards, all ensuring nurses had input into decision-making.⁸⁵ While SUN suggested that this input served to secure employment for their members and to ensure reform delivered Saskatchewan people a reasonable health care system, the sessions also allowed the government to keep close watch on issues.⁸⁶

Of all the unions, SUN remained the most supportive of reform throughout the tough year. It was confident that in spite of layoffs, there were still jobs for nurses. After all, the need for nurses still existed, especially as community-based services created jobs to replace those lost in the institutional sector.⁸⁷ Indeed, in the Saskatoon Health District "...most of the people who were laid off as a result of funding reductions last year were hired back into the system"⁸⁸ A more concrete sign of successful reemployment was SUN's dues revenue which grew in spite of layoffs. SUN also used the HRLTCC to gain job security provisions and transition support.⁸⁹

At the same time, SUN called for the government to honour its commitment to 'real' health system reform. It believed health reform offered its members significant benefits. Hence, it was no surprise when SUN's president rallied nurses in early 1993 stating, "Despite flaws in the process used by government...nurses must remain committed to health-care reform."⁹⁰ And similarly, "Despite the tremendous challenges facing nurses and their union...this phase of health reform was a window of opportunity for nurses to directly influence the shape of the future health care system...."⁹¹ So long as reform held out

promises of meaningful change, nurses committed to reform's difficult path.⁹² That said, SUN also reminded the government its support was conditional on those benefits.

As with nurses, the government dedicated significant effort to maintaining positive relations with the province's physicians through 1993. While hard to verify, a deliberate government strategy seemed to be to minimize reform's early impact upon physicians. This early reorganization and the hospital closures did not change physicians' work. The government also went out of its way to involve them in substantive decisions on physician-related issues and to work with them on shaping reform. Physicians' too received invitations to join local planning discussions and committees. The government also strove to develop cordial relations. Not only did this ease resistance, but physicians' even traveled across Saskatchewan with the government promoting Wellness.⁹³ Though these efforts proved successful, they also enabled the government to keep tabs on this group. Nonetheless, physicians still maintained at a high level of vigilance.

Importantly, the government's efforts were particularly strategic. Reform included a number of significant changes for physicians, key of which was remuneration and shifting oversight for physicians to districts. During the year, discussions focused on a central platform of Wellness: alternative remuneration.⁹⁴ The discussions, however, were short-lived. After a number of meetings and laborious exchanges, the SMA and physicians' refused to shift away from fee-for-service. The government backed away, indicating that voluntary participation was acceptable. Clearly, keeping the larger health reform agenda on track took precedence over arousing resistance from a key stakeholder. This retreat also highlighted the government's willingness to move away from reform's more worthwhile, but difficult, objectives when confronted by significant stakeholder pushback.

On the whole, this proactive stakeholder management enabled the government to successfully navigate the early months of 1993. It also should be recognized that a number of rural communities successfully transitioned to Wellness.⁹⁵ Early on these communities understood the inevitability of reform. One rural citizen stated “We feel fortunate that we have what we have....It’s less than what we wanted, but we still have a doctor and we still have services.”⁹⁶ The Melville Advance commented, “...we should remember the changes are not made for the sake of making a change. Changes are necessary. They've been long talked about and are long overdue. But it's only...this government who've had the courage to do something about it.”⁹⁷ Notably, these positive views of reform became important counters to the simmering anger of rural communities most affected by reform.

By the fall, however, simmering discontent led affected rural communities to organize. The August deadline for the establishment of districts passed with individuals from Eston and Radville writing to all 52 communities affected by hospital closures calling for a meeting.⁹⁸ In September forty met. After day long discussions the Rural Health Coalition (RHC) was formed with a mandate to advocate on behalf of rural communities opposed to cuts to their health services.⁹⁹ This became the first organized anti-health reform lobby.

Almost immediately, the RHC began a very organized, aggressive and public campaign to raise rural concerns about the loss of health services in their communities.¹⁰⁰ While the RHC was not against health reform, it did debate local planning committee decisions to move services out of their communities to larger centres.¹⁰¹ It believed these decisions were based on a town's hockey team rather needs.¹⁰² The government remained unsympathetic.¹⁰³ Simply, it was unwilling to interfere in decisions made by planning committees and boards.¹⁰⁴ Moreover, the government understood that in offering

concessions or backing down, reform might quickly unravel. It was not about to stop reform, though more importantly, it did not seem to consider the RHC, at this point, to be a credible stakeholder. An angry RHC lobbied through the media and the opposition, even threatening to take the government to court, though, the government remained unmoved.

While the government remained unwilling to bend to the RHC, it responded quickly to the SMA when in October 1993 physicians expressed anger over a government poll. The poll, which asked the public their views on physicians and various aspects of physician services, clearly was an effort by the government to test the waters on physician reform.¹⁰⁵ Notably, the poll overwhelmingly supported physician reform.¹⁰⁶ An infuriated SMA publicly attacked the government calling the government's action an intentional effort to provoke public outcry to force physicians to alternative payment schemes.¹⁰⁷ The outburst caused another proclamation from the government that it did not intend to force the issue.

In November, the depth of the government's unwillingness to confront physicians emerged again during discussion on shifting responsibility for funding physicians to the health districts. Physicians opposed this move since it meant their subjugation to health district management. The government seemingly worried by this response, once more retreated from a major component of health reform. Simard announced that the government aimed to administer a province-wide physicians' payment system.¹⁰⁸ In essence, it created a parallel system and physicians were effectively excluded from complete integration into health districts. The centralization of physician bargaining disappointed proponents of Wellness. It was contrary to the real intent and meaning of health reform and represented a major contradiction in Wellness, which was premised on the idea of local input and control. How could the health care system be locally controlled when health care salaries, which were

the largest single cost in the system, were controlled centrally? This ostensibly demonstrated the government's willingness to back away from the more strident aspect of reform when confronted with major criticism by one of the most powerful stakeholders.

Similarly, the government appeared to back away from imposing a solution to rural-urban physician distribution problems, a serious issue that exacerbated costs while doing little to increase rural access to health service. Instead, of imposing distribution quotas, the Saskatchewan Medical Council, made up of a variety of system stakeholders, was formed to study the issue.¹⁰⁹ A report from the committee was not completed until late October 1994.

Understandably, in the fall of 1993 public unease with health reform increased in step with the eruption of stakeholder discontent. The media carried every report of hospital closures, protests, rebelling rural communities of the RHC, and eruptions from stakeholders. Hence, September's poll saw over 52.4 percent of respondents disagreeing with government's health reform direction.¹¹⁰ This sentiment worsened in October when over 57 percent of Saskatchewan people stated they did not believe the government had done a good job reforming health care.¹¹¹ Most felt services had deteriorated and identified health reform with hospital closures and program cuts. A solid majority of 75.2 percent felt there had been too many cuts.¹¹² The government was losing the public relations battle. Declining public support clearly concerned the government.

Hurt by falling public confidence, concessions and retreats became the theme of 1994. As a result, a frustrated government, needing to end the months of RHC agitation, entered into discussions with them on a solution. An agreement arrived in February 1994.¹¹³ The resolution saw the government retreat again, committing funding for minimal service levels in certain communities, helping to attract more physicians, and providing more money

for emergency services.¹¹⁴ A dispute process was also created to assist health boards and communities deal with any future changes to health services.¹¹⁵ The latter most likely was an attempt to insert a process between the RHC and the government. Peace came at a cost of \$1.1 million to be absorbed into the 1993/94 and 1994/95 provincial health budgets.¹¹⁶ The Conservative opposition nonetheless criticized the government, suggesting that these rural communities had to drag Simard "...kicking and screaming to the table under the threat of a lawsuit...."¹¹⁷

Moreover, the government received a second shock in February when they lost a Regina by-election which saw health reform as a front and centre issue. An NDP incumbent seat held by long time politician, John Solomon was lost to Liberal Anita Bergman, a former Regina Health Board member.¹¹⁸ The support for Bergman was significant. The loss sent a strong message that all was not well with health reform.¹¹⁹

Improved finances meant that the government could offer some relief. The February 1994 Budget stated that the Balanced Budget Plan introduced in March 1993 was on track, provincial debt was decreasing and Saskatchewan's economy and job numbers had improved faster than the 1993 budget forecasts.¹²⁰ Indeed, the 1994 provincial budget was filled with good news, though for the most part, these were targeted spending injections in reaction to a year of prolonged public objections over cuts in the 1993 budget.

An evident response to the previous year's vociferous stakeholder outcry over health cuts was a \$14 million budget increase for the Department of Health for 1994/5. Home-based community services received more money to speed up the transition to community care from acute care services. Cuts to acute care, announced in the previous year's budget, were scaled back.¹²¹ This move eased, to some degree, fears of more job losses and bed

closures.¹²² Approximately \$7 million was targeted, based on population, to helping districts to enhance emergency services, home-based palliative care, and disease and accident prevention.¹²³ Another \$3 million was used for province wide initiatives.¹²⁴ Rural anxieties were also acknowledged. A new \$10 million Rural Initiatives Fund was unveiled, with much fanfare, to “...help ensure that rural health boards meet these locally determined needs...”¹²⁵ Importantly, this was not new money but consisted of funds reallocated mainly from acute care in order to quell problematic rural areas. The astute leader of the third party, Linda Haverstock, condemned it as a pretense commenting that “...while the government is saying there will be a 1.6 per cent increase in health care funding, there will actually be a loss of \$10 million in acute care funding...”¹²⁶

Just as the government believed that the budget eased tensions amongst health stakeholders, health board elections became an issue. Exact dates for board elections had not been included in the 1992 Wellness announcement, nor in the *Health District Act*. Simard, though, had hinted at that time that elections should coincide with those of municipal governments, scheduled for October 1994. Holding health board elections in conjunction with municipal elections reduced duplication and saved approximately \$500,000 in additional election costs.¹²⁷ Views, however, on the appropriateness of a fall district election date had shifted. At their January 1994 inaugural gathering, health board directors and CEOs supported a resolution asking the government to delay elections.¹²⁸ Elections so soon after the formation of districts and closure of health facilities would create a process “...more disruptive than constructive.”¹²⁹ Boards and CEOs felt that they were just becoming familiar with their responsibilities and much work remained before they would be ready.

There were also other considerations. The government, for instance, seemingly feared that elections could become a platform for angry communities and stakeholders. There were also concerns that these fledgling boards could become overrun with single-issue members. The government also agreed that the appointed boards needed to finalize their work before taking on what could be a sizeable number of new inexperienced members. In light of these issues, Simard announced that the government would take time to review the issue.¹³⁰

Simard's decision was not well received. Affected rural communities, believing that elections provided a venue to air their grievances with health reform, or even to halt the process in their district, were angry. Some unions saw elections as an opportunity to press their issues. CUPE, for example, argued that unelected "...boards are making decisions on a daily basis that affect workers in health care institutions and in communities they serve..."¹³¹ The media too shared this view suggesting that a fall election made sense and avoided costly duplication.¹³² Likewise, the opposition publicly noted all of these concerns and used the issue to launch another vitriolic attack on the government.¹³³

After weeks of relentless pressure Simard appointed Garf Stevenson as a one-person commission to study district health board elections.¹³⁴ As expected her decision was not well received. Scathing criticisms were lobbed at the government.¹³⁵ In the end, a major plank in the Wellness agenda, health board elections, became one more negatively charged public debate that the government needed to manage.

Controversy over health board elections worsened the impact of the implementation of needs-based funding. Essentially, beginning in April health districts received global funding as determined by the new needs-based funding formula. District funding shifted from a

historic usage-based method to a formula that funded programs and services based on population and health needs. On the whole, the impact of the funding shift was large, so much so that the government phased it in over a period of time to allow for adjustments at the community level. Hence in 1994-95 approximately 60 percent of funding provided to health districts would fall under the needs funding formula. The remaining 40 percent was scheduled to move in the next year. Even with the phase-in, districts saw their funding fall, both in 1994 and in 1995. Cuts were imminent.

The result was more criticism of the government and reform. Both the opposition and rural people argued that the new funding formula offloaded difficult decisions onto local boards.¹³⁶ The media carried stories of rural people's fears of having to travel great distances for care. Sick and elderly family members faced relocation to facilitates somewhere in rural Saskatchewan. Communities were being destroyed.¹³⁷ Once again, the government faced searing criticism of its reform.

Unfortunately, patience from key labour stakeholders was also diminishing. The management of these large health districts was a challenge for new board members and inexperienced CEOs. In many cases, they lacked the training and skills to manage human resources in these highly unionized environments. They had to deal with larger budgets, sizeable capital assets, and delivery of a wide-range of programs and services. As a result, unionized and non unionized employees alike grew frustrated with the disorganized nature of health reform and the confusion in workplaces. Their impatience was exacerbated by what seemed to be never ending fiscal restraint. Complaints grew.

SUN in particular was frustrated with reform.¹³⁸ It noted that "Health reform so far has been characterized by layoffs and chaotic planning...",¹³⁹ and it believed that "...things

will get worse.”¹⁴⁰ Difficulties with employee transfers among institutions within districts were not being resolved. Recognition of rights and obligations covered by existing collective agreements were problematic. Increased workloads were also an issue and SUN accused health boards, which faced limited funding, of not properly staffing some facilities. In early 1994, SUN took its concerns to the media over an issue of nursing staff levels, or lack thereof, in the Tisdale district. The government, as usual, quickly responded with a SUN-district commission to study and resolve the issues. While the commission supported SUN’s accusations, a few months later, SUN was back in the media complaining that the government and the district were ignoring the report’s recommendations.¹⁴¹ Simply, the district did not have the money to fix the problem.

These disputes gradually eroded SUN’s support for health reform and added to nurses’ discontent. The government, sensing SUN’s shifting sentiments, provided them with a \$12.7 million in-scope salary settlement in the February budget.¹⁴² This was another attempt at a concession to keep a stakeholder on side. The value was short-lived. By March concerns over health restraint erupted again. In Saskatoon the closure of the Saskatoon City Hospital Emergency particularly angered nurses. The nurses collected over 2,000 signatures and organized a sizeable protest that garnered support of more than 100 doctors.¹⁴³ The response overwhelmed the Saskatoon Board. It also caused unease in the government.

By the 1994 SUN Annual Meeting, nurses’ frustration was unmistakable. They vocalized anger, irritation and concern over the impact on their jobs, their workplaces, and rural Saskatchewan of two years of health reform. They were unhappy. As a result, nurses directed their leadership to investigate affiliation with the Saskatchewan Federation of Labour (SFL). This move sent a red flag to government.

In essence, with every passing month, SUN grew more skeptical of the government's commitment to the benefits that reform offered to nurses. The government tried to engage SUN with more invitations to participate in government-stakeholder discussions and to sit on committees yet SUN was tired of these requests. Committees were not resolving issues. SUN merely grew leery of these invitations. In effect, SUN's tolerance for reform was failing.

Even so SUN continued to refrain from attacking health reform. This tepid response did not go unnoticed. In the closing months of 1994, the media commented that "...the NDP government can shut down rural hospitals and there is no sustained opposition from groups affected, such as the nurses union..."¹⁴⁴ Simply, nurses retained some hope that Wellness may deliver its promised benefits to nurses.¹⁴⁵ More likely, SUN did not have many options.

Polling showed that the public support for reform had improved. In the April-May 1994 poll, health ranked 4th on their list of priorities, and 67.6 percent of residents still ranked Saskatchewan health care as good or excellent.¹⁴⁶ Over 78 percent of people rated the government's health reform agenda as fair to excellent.¹⁴⁷ By a large margin, hospital closures were the number one issue.¹⁴⁸ A quick response by the government – the agreement with the RHC, a relatively good news budget, retreats that had quieted physicians, and salary increases for nurse – all contributed to a reduction in stakeholder complaints and thus, a shift in the public perception of health reform. Moreover, in continued tight fiscal times – one good news budget did not erase many years of fiscal crisis messaging – the government still had the upper hand; restraint needed to be shared even in the health sector.

Undoubtedly, the government was also aided by a weakened opposition. Burdened by the legacy of an abysmal record in government which included poor oversight of Saskatchewan's health care system, the Conservatives lacked credibility. The Liberal

opposition bereft of members in the Legislature were largely left out of the discussion on health care. Moreover, in February the Liberal leader had stated her party's support for reform noting that it was inevitable and even necessary,¹⁴⁹ though, she criticized the government for undertaking reform for the wrong reasons: "They have changed health care because it was too expensive..."¹⁵⁰ As a result, there was no political alternative.

Furthermore, the government was also buoyed by the support of a large number of media members. This support came in spite of the emotive stories offered by the opposition and the complaints by, and at times, outright resistance to health reform by health stakeholders. The media defended Romanow suggesting he had no choice, that "...modernizing health care to meet the province's fiscal and demographic reality was crucial... it was the right policy."¹⁵¹ Thus, the NDP felt confident that health reform was on the right path.

Besides, not all stakeholders were up in arms. Through the early months of 1994, physicians remained on the sideline of reform. They had won the day on key issues like their remuneration and having the government responsible for their fees payments. The government's apparent unwillingness to confront its physicians aided in quieting them. This fact had not gone unobserved, caused one media outlet to comment in early 1994 that "...the Romanow government has carefully avoided one of the most critical issues. There has been precious little if any, talk about what to do about doctors. The people who have tremendous control over both supply and demand on the system have been mostly left out of the equation."¹⁵²

Yet, the physician's role within the reorganized structure was still, in spite of the government's public unwillingness to force physician reform, an important piece. As the

regionalization process progressed, discussions continued between the SMA and the government on physicians' integration into the new health districts structure.¹⁵³ Moreover, the government was clear that its long term, "...vision included the integration of physician services with the district management of other health resources and programs..."¹⁵⁴ The new health boards were to be responsible for physicians as part of their responsibility for the management of health district services and programs.¹⁵⁵ In fact, \$2 million dollars was quietly set aside within the 1994 budget for initiatives to facilitate the pace of this physician integration and to ease any tensions that might appear.¹⁵⁶

The summer however, gave way to more complaints from the RHC communities who turned to threats of a lawsuit, angrily proclaiming that "Bean counters have a bigger role setting policy than medical staff in the province's new approach to health care."¹⁵⁷ More importantly, in August, health boards and physicians publicly and aggressively, clashed.

Having found their feet after almost a full year of operation, and importantly, facing tight budgets, health boards turned to exerting control over its largest cost driver; physicians. The problem first arose in the Saskatoon Health District where admitting privileges for new physicians to Saskatoon hospitals was restricted. A resolution on the matter was achieved when the district backed down, though physicians henceforth remained wary of the board. Yet, this was only the beginning. Problems escalated into the fall when physicians and health boards once again quarreled. Physicians decried the health districts' exertion of authority over physicians' scope of work and responsibilities,¹⁵⁸ noting that "The authoritarianism and managerial inexperience in many rural districts was really causing the problem..."¹⁵⁹ They felt districts did not consult.¹⁶⁰ Their complaints caught the government's attention when they began to suggest that unless relations changed, there was sure to be an exodus of doctors

from Saskatchewan. Hence, with trouble brewing, the government brought the SMA and SAHO together to “...develop a framework agreement addressing key concerns.”¹⁶¹ The agenda included discussions on legal protection for physicians in their dealings with health districts, the establishment of a medical advisory committee in each district, remedies for working conditions and practice issues and an examination of alternative payment mechanisms.¹⁶² With a dialogue in place, tensions eased between the two parties. However, by intervening, the government clearly signaled its willingness to side with its physicians. Again, the government believed it necessary to retreat in order to keep an overall vision of reform on track.

By the end of the year, with health districts trying to exert control, the government pressing on the remuneration issue, and facing continued criticism from other health workers, physicians felt “...bashed and blamed...”¹⁶³ At their November meeting, the SMA President decried these attacks. He noted physicians were not opposed to health reform, including hospital closures as a way to increase the efficiency of the system. Nevertheless, in one of the first assertive proclaims from the SMA, he noted physicians “...had no meaningful input into health reform, they were losing their autonomy, had concerns about patient care and fear of uncertainty for their future.”¹⁶⁴ Health reform essentially created more work for physicians while delivering worse patient care.¹⁶⁵ If Wellness continued on this current path, he proclaimed “...the province could face the biggest threat to Medicare since the 1962 crisis...”¹⁶⁶ Yet, even with these strong comments, the SMA did not call for physicians to oppose reform.

As the year ended, the polls clearly showed that the continued stakeholder outcry weakened public option. An October 1994 poll identified that while the public still

supported the idea of health reform, 75.9 per cent of people felt that there had been too many budget cuts.¹⁶⁷ In spite of concessions and retreats, stakeholders were beginning to win the public relations battle.

On the whole, during two difficult years of health reform, the government had successfully moved its agenda ahead, including spending constraint and hospital cuts, needs-assessments and the creation of health districts. Yet, in the face of stakeholder resistance to these changes, and thus declining public support for reform entirely, the government turned to concessions and spending to control and ease the pain of health changes. These retreats proved to be obvious signals to stakeholders and set in place a pattern whereby stakeholders slowly eroded away the difficult and, at the same time, more meaningful tenets of health reform. More importantly once this pattern was embedded during 1994, reform's unwinding appeared a certainty in light of a stabilized and improving fiscal environment, and with an election on the horizon. Thus, even as the government deserved credit for steering the health system through many difficult policy choices, relatively unscathed, the only question remaining, was how long until reform ended.

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⁵ Saskatchewan, Saskatchewan Budget Address March 1993 (Regina March 1993), 44 - 45.

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⁷ David Roberts, "Undisclosed Federal Bailout Averted Crisis in 1993," The Globe and Mail March 22, 1997, 1.

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¹¹ Louise Simard, Saskatchewan Legislative Assembly Hansard Regina March 10 1993, 245-247.

¹² Louise Simard, Saskatchewan Legislative Assembly Hansard Regina February 21 1994, 321.

¹³ Amanda M James, "Closing Rural Hospitals in Saskatchewan: On the Road to Wellness?" Social Science and Medicine 49 (8) 1999, 1023. See also: Pammla Petrucka and Donna Smith, "Select Saskatchewan Rural Women's Perceptions of Health Reform: A Preliminary Consideration," Online Journal of Rural Nursing and Health Care 5 (1) Spring 2005, 65 - 66.

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- ²² News Release: Simard Releases Details of Health Budget.
- ²³ Dan D'Autromont, Saskatchewan Legislative Assembly Hansard Regina March 22 1993, 493.
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Chapter 4: The End of Health Reform: A Slow Unwinding

While 1993 and 1994 were pivotal years for health reform, in 1995 and 1996 the government began, directly in response to problematic stakeholders, its full retreat from this policy direction. The government deemed concession to be a tactic necessary to ensuring reform remained on track. As a result, it provided a small spending injection in 1994 the provincial budget and advanced other smaller efforts over the course of the year. Yet, while on the whole the compromises succeeded -- of stage one, only health board elections remained to be completed -- they also clearly signaled to stakeholders that pressure created compromise.

Where holding stakeholders to small compromises proved feasible when a fiscal crisis backstopped these retreats, the changing provincial fiscal and economic environment meant a number of problems emerged on the reform horizon during 1995 and 1996. Of these, the province's fiscal recovery was the most significant, though the provincial election proved just as important. The fiscal recovery begun in 1994 continued into 1995 and 1996, by which time, stakeholders understood its continuation was assured. Positive fiscal news effectively ended the government's vital reform anchor. The provincial election also proved problematic. Understandably, messaging around the fiscal turnaround and future economic prosperity, replaced those of a fiscal crisis, restraint and cuts.

As a result, the dynamic stakeholder environment took control of reform. Absent the fiscal crisis, and in light of the election messaging, their public outcries grew more vociferous and difficult to contain. At the same time, improved finances made it easy for the government to continue to offer concessions to keep reform on track, though in the end, concessions simply led to more demands from stakeholders, who effectively juxtaposed the

province's fiscal recovery against reform's restraint. Each time the media became the stage for this drama. The public's tolerance for reform eroded. A government once proficient at adapting to reform's challenges now struggled and failed to find the momentum to continue. This chapter examines reform's final unwinding, and more importantly, analyzes how stakeholders gained control of the health policy agenda and why the government failed to stop this occurrence.

Early in 1995, positive news once again emerged on the economic front. The economy grew and unemployment fell. Moreover, the government's fiscal management plans were on track. In the budget speech on February 1995, the Finance Minister MacKinnon proclaimed that Saskatchewan was "...beginning an era of greater financial security and freedom."¹ She revealed that "Not only would there be a balanced budget with a surplus of \$119 million for 1994/95, this surplus would be followed by three more years of small surpluses beginning with a projected \$24 million in 1995/96."² Though good news, the government also indicated its intent to stay committed to a fiscal management strategy.³ This meant staying focused on balancing the budget, paying down the debt, reducing selected taxes, and selectively increasing spending in targeted areas.⁴

In light of the good budget news, the government also needed to be politically sensitive. Ongoing and loud complaints by health stakeholders convinced the government that the health sector needed some good news too. Simply, in good fiscal times, harsh health spending restraint needed to be eased slightly. More this was an election year. At the same time, the government did not want to return to pre-reform spending habits. Thus the budget provided a 3.4 percent increase in health spending,⁵ double the 1.6 percent increase in the 1994/95 budget.⁶ Though significant, only \$20.3 million was new. The reset of the money

covered the transfer of Department of Health employees to the new health districts.⁷ The new funding targeted community based care, while one percent was for hospitals and 3.1 percent for nursing homes.⁸ Notably, the Rural Health Initiatives Fund announced a year earlier, silently reverted back into the funding pool for health districts.⁹ While it had served the purpose of quieting the RHC, the new funding for health hid its disappearance.

Tactically, the government determined that it needed to capture as much positive new as possible around health care. Thus, a pre-budget press release announced the \$20.3 million expenditure.¹⁰ It also proclaimed that the money represented a new beginning for health reform in Saskatchewan.¹¹ Furthermore, the money meant more than 460 jobs for nurses, home care aides, therapists, and counsellors.¹² At the same time, the government attempted to present this new direction as one of fiscal control instead of cuts. A seeming response to stakeholder calls to end the cuts and job loss. Notably, the opposition parties quickly claimed that the injection of new funding indicated that reform had failed.¹³

Regrettably an array of negative issues once again spoiled the good news health spending story. The first troubling sign emerged a week before the budget, on February 2, 1995 when Louise Simard stepped down as the Minister of Health.¹⁴ She initiated, understood the long-range goals and captained the government's health reform. For two and half years, she bore the brunt of stakeholder anger with health reform. Her departure did not bode well, as for many it signalled a potential waning of the government's commitment to reform as well as potential dissention over health reform within the government ranks. The timing of Simard's departure, before the budget, hints that this was also an effort by the government to distance itself from the previous bad news of reform.

February also saw the government reignite controversy over health board elections. It announced that it planned to appoint four of the twelve members to rural boards, and in Saskatoon and Regina, half of the board.¹⁵ Not only did this signal a retreat from the government's long heralded democratic election process, it also hinted at the government's failing confidence in the community-based process. As expected, the media and opposition chastised the government for appointing board members after committing to electing boards democratically.¹⁶

At the same time, and seemingly surprising the government, the question of health board election eligibility also arose. Not only did the government not have an answer, it again found itself involved in an acrimonious public debate. The SMA, SUN and other health unions ignited calls for health employees to be made eligible for election. They hoped to stop the government from further influencing the makeup of boards. Elections were an opportunity to elect their own members, who could then to advance their interests on boards. On the other hand SUMA and SARM were opposed.¹⁷ Making matters worse, the issue of a health board elections date also remerged in the media, as did reminders of its unnecessary cost and duplication, juxtaposed against the government's previous obsession with health spending restraint and efficiency.¹⁸ This debate lasted throughout the spring of 1995.

RHC issues also reappeared in February. The government, it complained, had reneged on the terms of the Agreement. Many rural communities still did not have adequate health services.¹⁹ The media again took notice, while the opposition raised their complaints at every opportunity, citing the RHC's concerns as more examples of the government's failure to listen and to keep promises made to rural communities.²⁰ A very frustrated government tried to argue otherwise. Hospitals had not closed. Funding had been provided

for home care, health centres and other health services.²¹ This failed to ease the agitations and anger of the RHC,²² nor to reduce the level of media coverage of the RHC's concerns. More often than not, the RHC problems detracted from the government's success stories in rural Saskatchewan.

Further marring the government's good news budget and increased health spending, the financial pressures facing health boards became known in March when health districts released their 1993/94 financial statements. After one year of operations twenty-nine of 32 health districts reported deficits totaling \$15.1 million.²³ Almost all districts had failed to manage the government's funding restraints and their own increased costs. The opposition demanded that the government provide more money districts;²⁴ not doing so meant districts going broke. It meant the closure of more hospital beds and loss of services and jobs.²⁵ Moreover, the media and the opposition made it obvious that the government's increased spending on health in the budget was too little and too late to alleviate these deficits. In most districts, fiscal problems were chronic, and as the opposition predicted, necessitated cuts.

Adding to the government's problems during these early months, cash strapped health district ended up in public clashes with physicians, again. Notably, negotiations begun in November 1994 on relation between the SAHO, health boards and the SMA continued, but did not slow health boards' efforts. Simply, with scant fiscal resources, board needed to exert control over physician services and physician numbers since these areas significantly impacted their budgets.²⁶ Hence, physicians grew angrier by the week.²⁷ Moreover, it publicly challenged the government to intercede to curb the boards and speed up the negotiation, or else. In a very public media battle, a frustrated SMA threatened to form a union for physicians' to ensure physicians' rights were protected against the power of the

boards.²⁸ Frustrated physicians would depart leaving communities without care.²⁹ These threats caught the attention of both the government, the media, and more importantly, of the public who worried about availability of their health services both in rural and urban centres.

Also angering physicians was slow progress of negotiation for a new service agreement. As a result, another emotional public debate ensued in the media. Their agreement expired a year earlier, in April 1994. Largely, the failing discussion on remuneration caused the delay, as simply, the SMA demanded an increase. The previous agreement reduced their fees by one per cent between 1992 and 1994.³⁰ In light of improved government finances and the disappearance of the fiscal crisis, physicians refused to compromise on their pay. A public campaign began with the SMA proclaiming that physician's bore the brunt of health reform. They had to work harder and longer under the reformed system. They had been blamed for the problems in the health system when in fact health boards were the problem. They proclaimed that health districts and the government had abandoned the patient because of reform and the focus on cost cutting. Only the physician stood as "... the best and last defense against mediocre medical care..."³¹ The opposition also fanned the public debate. Physicians, they argued, faced untenable choices about patient treatment because there was a lack of resources and beds due to reform's restraint.³² Patients had to travel further for care.³³ Hospital closures because of reform reduced access to beds and operating times. Saskatchewan's health system was failing. Health care in rural Saskatchewan was in trouble.³⁴ The government attempted to remain unmoved by the SMA's concerns. Acquiescing only opened the door to other stakeholder demands. However, the very public debate concerned the government. Indeed, the media and the public did not seem sympathetic to the government's defences.

At the same time, SUN too, in light of years of restraint, grew even more frustrated. An even more angry debate than the year prior highlighted the SUN's Annual General Meeting in April 1995, when over 300 nurses complain they had enough of reform. They tired and they endured an array of problems. Confusion, turmoil, poor leadership and lack of funding created pressure in their workplaces. Then nurses faced job losses, maximum workloads, growing vacancies, decreased staffing levels,³⁵ and all-pervasive stress.³⁶ They sat on a time bomb of potential disasters in many facilities. Nurses believed that they bore the heaviest burden of health reform. More importantly, nurses feared that future budgets meant more nursing job losses and worsening working conditions. Simply, fiscal restraint was wearing away nurses' support for reform.³⁷

Reform also failed to deliver real change. Many promises had been made and none had been delivered. SUN called for less focus on costs and more on health reform that delivered effective primary health services, and population based and preventative services.³⁸ There were repeated calls for integrated care, multi-disciplinary teams of salaried providers.³⁹ Even more disappointing, the government failed to tackle physician related issues. In fact, SUN despaired that the government "...made a tactical political decision not to put doctors' feet to the reform fire..."⁴⁰ Conversely, SUN noted that even during reform's restraint, payments to physicians for fee-for-service had grown.⁴¹ For nurses, the possibility that physicians avoided the pain of reform proved concerning and alarming.

Though nurses and SUN continued to demand that the government act to implement real reform⁴² -- without these reforms Wellness meant nothing⁴³ -- nurses' support for continued reform and even the government clearly shifted in 1995. At the 1995 Annual General Meeting a solid majority of nurse directed their leadership to be more vocal about

issues facing nurses.⁴⁴ They endorsed a proactive media campaign. They determined that all nurses must vocalize their criticism of the government's inaction on meaningful reform.⁴⁵ SUN for example, once appreciative of any new funds for nurses, now only demonstrated tepid support for the new dollars for in-scope salaries and new positions in the 1995/96 provincial budget. These funds in their view "...just filling in the cracks left by previous budgets."⁴⁶

Not only was the public suddenly subjected to media coverage of irritated nurses, the intensity of SUN's frustrations and attacks on physicians' even caught the attention of the SMA and physicians. At the SMA May 1995 Annual Meeting discussion on relations with other health care providers resulted in a conciliatory gesture. The meeting passed a resolution expressing physicians' "...concern about, and support for, all providers of health care adversely affected by health system down-sizing and that they be acknowledged for their efforts to provide quality care in spite of the unfavorable conditions that they are working under."⁴⁷ While not explicit, the SMA's effort to recognize the trials of health workers did not go unnoticed by either SUN or the public.

Physicians' sudden and surprising empathy for nurses arose because at the end of the day they too felt reform's pressure on key areas of their domain. In particular, health boards' efforts to exert their authority over physicians continued even though a Framework Agreement was signed in May 1995.⁴⁸ Importantly, the agreement defined physicians' roles in the health system and their relations with health districts, including how districts negotiated terms and conditions of engagement with physicians.⁴⁹ A dispute resolution process was created.⁵⁰ Yet, shortly after signing the agreement, physician-district relations grew tense again. Largely, even with agreement, budget strapped boards had no choice. For

example, just days after the signing, the Saskatoon Health Board attempted to restrict hospital privileges for its physicians.⁵¹ Understandably, with no relief available, boards' relations with physicians remained in a state of conflict. Unfortunately, these disputes played out in the media.

An upcoming provincial election meant that the frustrations of nurses and physicians concerned the government. Importantly, this frustration shifted the public's views of reform. A May 1995 poll found that health reform jumped two spots from a year earlier, to become people's 2nd highest concern.⁵² In addition, 41 percent thought government had done a poor job reforming the health system and over 58 percent said that health services had deteriorated.⁵³ Hence, just months after good news budget in February, the government was once again losing the public relations battle over health reform.

Notably the government needed to mend two problems if it hoped to stop health reform from becoming an election issue. Importantly, while not the sole reason for declining public support of the government, reform proved to be one of the more important.⁵⁴ In this regard, stakeholders concerns with health reform played a major role. Simply, the public seemed to be wearying of health restraint imposed on stakeholders during times of a good news budget. Thus, while not prepared to stop reform, the government responded by changing the messages. New about health initiatives and emphasized investments in community and home care became the focus. The government promoted increased funding for community and health programs. It no longer referred at all to fiscal management, health care cuts and reform.⁵⁵ As a result, health reform became health renewal.⁵⁶ This term conveyed stabilized funding for health services and assurances to health care providers that they would be involved in designing and implementing future health services.⁵⁷ More

importantly, these efforts worked. A Maclean's poll in June 1995 indicated that overall public support for the NDP rebounded to almost 51 percent.⁵⁸

As a result, health was not a major issue during the June 1995 election campaign. A couple of explanations could explain this outcome. While SUN's view of reform shifted, and in spite of the increased anxiety and frustrations of SUN's members, and though relations with the NDP government had become strained and SUN was skeptical about the NDP's commitments, SUN did not want to defeat the NDP government. Simply, they had no choice. The Conservatives and the Liberals offered no viable alternative; these parties had already indicated their support for continuing reform and historically, were not particularly supportive of unions. Yet, SUN did not endorse the NDP. Instead, SUN set out to raise awareness about nursing issues, about the state of health care and to win public support for these issues. If, and when, the NDP was reelected, SUN intended to be well positioned. Thus, through the election campaign SUN's leadership tempered its attacks on the NDP. Instead it launched its *time to blow the whistle* campaign.⁵⁹ The campaign focused on encouraging the public to call for the government to act on real reform: physician reforms, primary care, and the expansion of nursing roles and the roles of other health professionals in the system.⁶⁰ Questionnaires were distributed to 6,000 nurses asking them to track their experiences under health reform and to report instances where health care cuts jeopardized patient care. These emotive and personal stories offered the necessary ammunition to press the government into addressing nursing issues.

The SMA's approach to the election was similar to that of SUN. While individual physicians publicly noted their concerns with health reform in the media during the campaign, the SMA avoided public confrontations. They did not endorse any party and

focused their comments on issues around patient care, remuneration and health boards. Seemingly, like SUN, the SMA appreciated that given the probability of an NDP victory, elevating their concerns publicly offered more opportunity than siding with other parties to defeat the government.

Importantly, the problems in both the Liberal and Conservative campaigns also seemed key. Liberal leader Linda Haverstock, already a supporter of health reform, damaged her trustworthiness further when she admitted she, "...wouldn't roll back any of the NDP's rural hospital closures."⁶¹ More importantly, her criticisms of Wellness were dismissed when early in the campaign she became linked with the federal Liberal government's cuts to health transfers.⁶² Similarly, the Conservatives continued to be seriously hampered by the lingering scandals from the Devine years. Then, their leader, Bill Boyd, backed away from promising to reopen hospitals further damaging their credibility.⁶³ Then he suggested that the private sector might provide solutions to health care's problems.⁶⁴ In the end, according to the media, there were no health issues in the election as all parties agreed on the need for health care reform, and for government spending to be reduced.⁶⁵ Thus, even suggestions that Romanow avoided campaigning in constituencies where hospitals had closed did not become an issue in the campaign.⁶⁶

In the end, the electorate's message on health reform was mixed. Romanow's government won 42 of the legislature's 58 seats (in 1991 the legislature had 66 seats of which the NDP held 55). Though the NDP majority declined, the party captured 47 percent of the popular vote, down four percent from 1991.⁶⁷ The Liberals increased their seats from one to eleven, and the Conservatives dropped to five from ten, losing their official opposition status. In the twenty-three ridings where hospitals had closed, the NDP retained thirteen

seats, the Liberals six and the Conservative held four.⁶⁸ Liberal Jim Melenchuk, former President of the SMA, narrowly lost to the NDP incumbent after campaigning against the NDP on health care reform. On the other hand, Glen McPherson, a former NDP MLA who had crossed the floor to the Liberal's in August 1993, and who had been highly critical of government's health reform agenda, was elected.⁶⁹ Liberal Anita Bergman, who won a Regina by-election a few months earlier, was defeated.

For the most part, the outcome contained a number of meanings for the government. On one hand, a number of rural communities signaled displeasure with the NDP and reform, since NDP lost the majority of its seats in rural areas. The outcome might also mean that the victory handed Romanow a strong mandate to stay the course, including health reform.⁷⁰ Yet, one media report went so far as to suggest that the results did not mean people supported health reform, just that they had no choice: "There was no joy in voting NDP, not even for diehard social activists or union agitators who make up what's left of the left...but what other choice did they have?"⁷¹ In the end, the election provided the government with little measurement on overall public views on health reform. However, Romanow now faced a Liberal official opposition in the Legislature. These Liberals had a clear agenda aimed at aggressively opposing the NDP's health reform. This outcome, though insignificant at the time, meant there were credible anti-reform voices in the Legislature, and one individual with a personal grudge (Glen McPherson), targeted at health reform.

Following the election a lull settled over the province and the health system. That lull ended in August when the government announced an October 1995 date for health board elections, though, the controversy focused on the declaration that health care employees were eligible for board positions.⁷² The news attracted mixed reviews. Many, including the

media, worried about a deluge of health workers elected to boards and who could then skew the decisions of the boards. On the other hand, health stakeholders rejoiced. Now they could possibly move into leadership positions in their district and thus advance their issues and maybe obtain resolutions. As result, the government nonetheless faced having to again defend its decisions.

Interestingly, the real problem with the elections arose in September when nominations opened. The government faced immediate questions from the media and from the opposition over fears that special interests intended to dominate the elections. Ironically, months earlier the government identified the problem and had solved it when they decided to appoint board members. Yet, as predicted, though to the dismay of the government, health stakeholders organized and campaigned on single issues.⁷³ The Saskatchewan Health Coalition joined with SUN, the SFL and other unions to run candidates or to support targeted candidates. Together, they advocated for the Health Coalition's *Platform for Progress* which called for the protection and expansion of health services across Saskatchewan.⁷⁴ All told, coalition candidates represented fifty-five of the 509 candidates. SUN too encouraged nurses to take an active role in health board elections, and they financed a public campaign that encouraged support for nurses or candidates who supported nursing issues. These efforts paid off. Nurses captured over 31 percent of health board seats.⁷⁵

The outcome of the election proved less positive for the government. After years of working with appointed and generally supportive boards, it now faced elected health boards with strong interests in advancing their own agenda and issues. More importantly, the level of public apathy created a great deal of disappointment for the government. Few took notice of the elections, and even fewer actually voted. Simply, the much ballyhooed democratic

process had failed to garner much interest. The message to government was evident: ownership of their health system did not interest people, nor for that matter, did they seemingly want to participate in health reform. A government once enthused with health reform could only be disappointed.

In light of the election outcome, the government moved quickly to proactively prevent problems with the new and potentially activist boards. Soon after the elections the Department of Health organized a meeting with SAHO and the health districts to set clear guidelines around defining the new boards' roles, authority and accountability. The two signed a Framework of Accountability agreement that fall.⁷⁶ The framework defined the parameters and expectations of the partnership between government, districts and the public and laid out accountability measures for the use of government funds.⁷⁷ More importantly, it affirmed that the Minister of Health was responsible for the overall health system and made the boards accountable to the provincial government, not to their communities.⁷⁸ A Health Districts Advisory Committee was established to enhance communications and consultations between the Department and health districts. This too served as a buffer. It ensured that these new and possibly less amenable boards had an immediate conduit to the Department to circumvent any public discussion on issues.

Unfortunately for the government, almost immediately, the new boards faced old problems. The release of the 1994/95 fiscal statements showed that the deficits identified at the end of the previous year had not disappeared, though they were somewhat reduced year over year. Twenty-seven districts reported operating deficits which together totaled \$6.4 million.⁷⁹ While this was a significant drop from the previous year's \$15 million,⁸⁰ almost

every district lacked the funds to match growing expenditures. Hence, these deficits signalled ongoing and in fact, growing, financial problems.

In December, the new health boards, already alarmed by their own fiscal problems, grew agitated when the government signaled that cuts in federal transfers may be passed on to districts. For the current year, this meant a reduction of more than \$50 million in provincial health funding. More were to come in future.⁸¹ While it is unclear whether the government intended to use federal cuts as a new fiscal crisis and thus a need for ongoing provincial spending fiscal restraint, the announcement effectively created tension and anxiety amongst boards. SAHO publicly decried the offloading of federal cuts, claiming that it would lead to damaging reductions in health district budgets.⁸² Rather than cut health, SAHO argued, it would “...like to see that the pain is being felt across government...” that “Health has taken hard cuts in the past....”⁸³ The Saskatoon Health District and the Regina District expressed public concern over these cuts.⁸⁴ Even Saskatoon’s City Council took the unusual step of devoting a portion of its agenda to discussions of the impact of these federal cuts on Saskatchewan’s health care.⁸⁵

SUN too became alarmed. More district budget cuts meant the loss of jobs and increased workloads for nurses. A distraught SUN responded in November 1995 by launching another very aggressive public education campaign called *Stop the Silence*. Nurses were told to take a stand in their workplaces against inadequate staffing levels and heavy workloads which prevented appropriate nursing care. Violations of nursing standards were to be documented. In addition, SUN initiated a billboard campaign highlighting the deterioration of patient care and increased workloads for nurses. The campaign also pointed out that Wellness cuts costs and nothing more. If the government truly wanted for reform it

should deal with physicians, who in their view, had been excluded from health reform, while protecting nurses and beds, both of which had been slashed.

Importantly, SUN's increased activism occurred in step with its contract negotiations with SAHO. The collective agreement expired in March 1996 and initial conversations with SAHO suggested that SUN faced a tough bargaining environment. Yet, nurses were aware that the government had just signed a generous new service agreement with the SMA. This simply annoyed SUN, who viewed it as a signal that the government feared taking a stand against physicians. Physicians received a fee increase of 2.5 percent.⁸⁶ A onetime bonus of \$1.1 million was to be distributed amongst the province's 1,200 doctors.⁸⁷ Physicians also secured a commitment that a new payment system would not be implemented in the near future. While the government hoped the agreement alleviated the anxiety felt by Saskatchewan's physicians,⁸⁸ SUN was not impressed. It suggested the contract was, "...generous given the provinces finances."⁸⁹ More likely, the government used contract negotiations with the SMA to reduce growing physician unrest, while it seemingly had less concern over nurses' unrest. Needless to say, it had the opposite effect on SUN. SUN no longer believed that the government desired real change; instead, the government agenda was about reducing costs by shifting the burden to nurses.⁹⁰ This marked a significant turning.

Health board reactions to potential cuts, as well as angry nurses, had the government backpedaling by December on its suggestion that it intended to offload of federal cuts through to districts. Rather than passing them through, the government retreated, commenting that the province would look for ways to "...cushion the blow."⁹¹ Though this alleviated tension around future funding for health care, it also demonstrated an unmistakable retreat by the government. Stakeholders now understood that provincial fiscal crisis no

longer constrained the government. More importantly, it became evident that improved government finances and provincial economy meant backing away was easier than the pain of adhering to fiscal constraint. Thus by the end of 1995, the government faced a double edged sword: it remained committed to health spending restraint while no longer facing a fiscal crisis.

The March 1996 provincial budget illustrated the depth of the problem. The budget forecast an improved economy, a year end surplus of \$8 million, and a projected surplus of \$22 million for 1997/98.⁹² Enough money existed in the government coffers for a substantive pay down of the provincial debt, and for hints of possible tax cuts in the near future.⁹³ However, the budget also held health spending to zero percent for 1996/97 and for 1997/98.⁹⁴ Though federal cuts had not passed through to districts, this was still not good news. The government's zero percent really created, for most boards, a two to three percent cut, with inflation and other costs.⁹⁵ This proved difficult. Boards had already made significant reductions in operating costs over the previous two years. They had used amalgamations, reductions of duplication and waste, and improved system efficiencies. Most had spent their reserves and many ran deficits. No increase in funding for two years meant that health boards needed to again turn to program and service cuts. They had no choice. Yet, further cuts were not only ill advised, but in their view, undermined Wellness.⁹⁶ The government, however, was unsympathetic. Boards were told that the province did not intend to cover deficits; health boards needed to find ways to manage these shortfalls within the funding they received.⁹⁷ As expected, health boards and stakeholders felt anger over the government's seemingly hard response. Interestingly, even the media portrayed it as bordering on insensitive.

Further aggravating this anger, in April 1996 the government announced the final 1996/97 breakdown of needs-based funding.⁹⁸ The formula imposed budget reductions of as much as 3.3 percent for nineteen rural health districts.⁹⁹ Left with no choice, cuts began anew. Immediately, the cuts hit senior's complexes, nursing home beds and special care homes in a number of rural communities. More nurses, along with other health care workers, lost their jobs. News of these cuts sparked anger throughout rural Saskatchewan. Once again, the rural media was filled with stories condemning the government over its disregard for rural communities.¹⁰⁰ These stories also now told of seniors separated from each other or from their families. Yet, urban districts fared slightly better.¹⁰¹ Though, eleven saw funding increases,¹⁰² these funds were not enough. Even with an additional 0.5 per cent in new funding, the Saskatoon Health District predicted layoffs and reorganization because of an operating shortfall.¹⁰³ Similarly, the Regina Health District's \$13 million shortfall over two years meant cutting one hundred jobs and closing sixty-four acute care beds and a twenty-two bed senior's facility.¹⁰⁴ The Regina district also reaffirmed its 1993 decision to close the Plains Hospital triggering another round of large public protests in Regina. An exasperated board defended its decisions by noting that it "...really had no other viable opportunity or alternative because the Government basically said we will just cut the funding if you do not continue the process."¹⁰⁵ Again, the media filled its pages with stories of cuts, job losses and upset health workers and patients.

SUN, facing the loss of more nursing jobs, was truly angered. Nurses yet again seemingly carried the burden of the cuts. On top of these cuts, the slow pace of their contract negotiations made them even angrier. SAHO refused to find the funds to resolve nurses' issues; the government refused to provide funding to pay for a contract settlement.¹⁰⁶

Though wages were the key issue, other issues garnered higher levels of interest: pensions, job protection, workplace stress and staffing levels.

Frustrated, depressed, and demoralized nurses at SUN's 1996 spring Annual General Meeting voted overwhelmingly in favour of joining the SFL.¹⁰⁷ Once supportive of the government and health reform, nurses now believed they had no choice. They needed organized labour's help in protecting their interests. Though ratification of SUN's membership in the SFL was not scheduled until the November 1996 SFL convention, the moment SUN passed the resolution, the concerns of SUN's members instantly became the concerns of 70,000 unionized workers in Saskatchewan.¹⁰⁸ Suddenly, every one of these workers became informed of SUN's struggles and the problems in the health system.

SUN also began immediately to publically criticize health reform. In the media, at public and private meetings, it demanded that the government provide more money for health care.¹⁰⁹ SUN shrewdly argued that lack of funding hindered patient care and safety. Layoffs, stress related sick leave and unsafe working environments endangered the well being of Saskatchewan's health system.¹¹⁰ Without more money, health districts put the bottom line ahead of patient wellbeing and the reason districts had no money. The emotional attacks honed in on one fact: "...the province has to provide more cash..."¹¹¹

Physicians too expressed growing concerns and even opposition to health boards and health reform, the latter of which caused the problem. Pressure from the health boards, largely due to growing financial difficulties, continued even with the agreement in place. In fact it worsened. Hence, physicians took to blaming health boards for a range of problems: failing patient care; difficulty accessing beds and services; reduced auxiliary services; nursing cuts; and increased physician workloads. Moreover, rural physicians, the hardest hit

by the governments' restraint, were at the end of their rope. None of the government's promises materialized. There were fewer, not more physicians practicing. Physicians now travelled further distances. They often worked seven days a week without a break. Access to quality health care was deteriorating in rural Saskatchewan,¹¹² while waiting lists increased.¹¹³ At the SMA Annual Meeting in April an annoyed group greeted the Minister of Health's visit.¹¹⁴ Frustrations were loudly expressed.¹¹⁵ The meeting heard that 60 percent of physicians intended to leave Saskatchewan if workloads were not reduced.¹¹⁶ Even foreign doctors did not want to work in rural Saskatchewan because of these working conditions.¹¹⁷ Even more disturbing for the government, the public responded by indicating its empathy for physician complaints.

Likewise, the Minister of Health encountered 350 angry health board members and CEOs at SAHO's quarterly meeting in May 1996. These discussions contrasted starkly with the reception given to the Minister at their inaugural meeting in December 1995.¹¹⁸ They challenged him on a range of issues, of which funding ranked first. Participants also raised the issue of the workplace moral: nurses and physicians were in uproar.¹¹⁹ While less public about their concerns, on the whole, boards tired of acting as the intermediary between the government and nurses and physicians. The message, though, clearly conveyed their frustration and concerns about finding no relief from the government.

These numerous heightened public confrontations involving the government and nurses, physicians and health boards carried an ominous signal that reform was stalling. The media aggravated the tone not only by their level of coverage of the issues. In turn, they too began questioning health reform's direction. In particular, health boards received a sympathetic ear, while the government was criticized for dodging its responsibility for creating the

problems. One media commentator observed that “It’s time that [Eric]Cline [Minister of Health] and his colleagues stopped using the health boards as a shield and accepted the responsibility for the government’s financial decisions.”¹²⁰ Another media story noted that “Instead of dealing with problems directly, it [the government] has abdicated its public and political responsibility by passing off the problems onto local health boards that are unable to cope with the situation dumped on them.”¹²¹ More importantly, the media challenged the government’s leadership: “What’s developed is the perception that the Romanow government has, in essence, abandoned the health-care system.”¹²²

Regular media reports about the failings of health reform grew over the spring months with each new stakeholder flare-up, and significantly damaged the government’s leadership and credibility. The reports spoke of substandard care, of cash strapped hospitals requiring patients to supply their own soap, slippers and house-coats,¹²³ of weeping seniors relocated to distant facilities, and of patients having to lay in hallways for hours or even days for care.¹²⁴ The opposition, seeing the deteriorating views of reform, increased its attacks bringing forward more emotional tales of a failing health system. The government soon detested attending Question Period because of the endless health care stories.¹²⁵ Indeed, by the end of the 1996 spring session the Minister of Health fielded more than 700 questions; twice as many as any other minister.¹²⁶

Public opinion of reform worsened over the summer largely in response to these escalations in stakeholder commentary and media reports. Unfortunately, even positive news on reorganizing labour relations in the health sector garnered very little response from stakeholders. The *Health Labour Relations Reorganization Act* tasked a commission (Dorsey Commission) with completing a comprehensive review and reorganization of

collective bargaining in Saskatchewan's health sector.¹²⁷ For many, the effort came too late. Frustrated and discouraged employees and health boards, besieged by the problems of health reform, simply they no longer believed that anything associated with reform offered positive results.

Moreover, health districts also became more vocal. In essence, the elected health boards, possibly due to their large stakeholder representation, emerged as independent and very credible commentators on the health system.¹²⁸ They were no longer sycophants of the government, but democratically elected local bodies expressing serious concerns. Funding issues pushed them to the edge. As a result, they publicly pressed the government, calling for increased funding and then threatened job and service cuts if none was forthcoming. The board's criticisms, more so than any other stakeholder, caused a serious problem for the government.

Likewise, rural people too scaled up their longstanding resistance to reform.¹²⁹ Over June and July six communities sued or announced plans to sue the government over health care funding. To the dismay of the government some of these communities won their lawsuits, validating accusations that the government had failed to act to protect rural health care.¹³⁰ In addition, the RHC also began to agitate again. It stated disappointment, frustration and anger, at what it considered to be the government's unwillingness to honour the Agreement -- funding for services in their communities.¹³¹

In response to the intensifying negative views of reform, the government tried to stop the damage by providing its members with good news stories and facts on health reform and more importantly, on the state of Saskatchewan's health system.¹³² Importantly, the documentation distanced the government from the cuts and reorganization associated with

health reform and spoke of investments. Gone too was any reference to health reform and Wellness, or the Vision for Health Care. Instead government members referred to health renewal.¹³³ This effort did not work. Good news stories from politicians could not convince a public inundated with stakeholder stories of their experiences with a failing health system.

Moreover, pointing the finger at the province's financial problems was quickly discouraged. The government had learned the hard way that improved finances no longer, even in the face of limited revenues, justified reform. One media story noted for example that, "Blaming it all on Ottawa becomes the obvious defence but there is a big problem when pleading poverty...This government is receiving an extra \$100 million a year from VLTs and casinos and has just received a \$50 million-dividend from its Crowns."¹³⁴

In effect, by the end of the summer of 1996, almost every stakeholder in the province voiced opposition to continued health reform and specifically, to continued health spending restraint. These voices focused singularly on ending to cuts and adding new funding for health. By the end of the summer, the government faced a wave of anti reform sentiments.

Its fortunes worsened. SUN began an aggressive set of anti health reform campaigns. Each focused on raising concerns with staffing levels and patient safety while calling for more funds. The first campaign encouraged nurses to speak out, write a letters, organize and attend meetings to raise public awareness of nurses' frustrations and of the stresses caused by reform. As a result, passionate letters appeared in newspapers. One for example, expressed heartfelt frustration: "The health-care system is at a breaking point...We can't cope any longer! We can't do more with less...."¹³⁵ Whenever possible – at public meetings, call in shows, and MLA offices– nurses told tales of harassed and tired nurses, poor patient care and of stress.¹³⁶ Then SUN began a second campaign: "*Stop the Silence*". The campaign raised

public awareness about the crisis in health care and the failings of health reform by releasing daunting testimonials gathered during the nursing survey from the previous year's *blow the whistle campaign*.^{137 138} On the heels of this campaign, SUN then launched another. In August over 147,000 pamphlets were distributed door-to-door in Saskatoon, Regina and 100 other communities,¹³⁹ and eight billboards appeared across the province reading: '*Is health care in crisis? Ask a registered nurse.*' Each pamphlet was tailored to a specific community and had a tear off portion for comments, which the public was asked to return to SUN. The response was overwhelming. SUN delivered, in publicly staged events, boxes upon boxes of tear offs to the Minister of Health. Each carried a story of an ailing health system.¹⁴⁰

During the summer of 1996, SUN made another strategic decision and one that had dire consequences for the government. SUN's public criticisms of physicians disappeared. Though not a formal coming together, SUN now aligned itself with physicians under a common concern: ending cuts and increasing health funding.¹⁴¹ Calls for physician reform vanished. SUN also toned down appeals for moving forward with wellness. Ultimately, SUN and nurses alike now concluded that reform's promises to nurses' meant nothing. Simply, the government did not intend to carry out its commitments – integration of medical services, expanded roles for nurses and community health centres – to nurses.¹⁴² Physicians and the medical model would continue to dominate. Ongoing reform only meant more cuts and job losses. In the end, SUN believed reform doomed nurses and patients to more pain. SUN's president summed up nurses' views: "If reform continues as it has, the system will 'flatline' the same way a dead patient does."¹⁴³ Working alongside physicians to stop reform was their only alternative.

Suddenly, with the convergence of SUN and physicians into a single voice against reform, the most powerful stakeholders stood united in their attack on reform and the government. Protests erupted again in rural Saskatchewan. With them all focused on condemning reform, public perception shifted. The public became convinced that reform hurt the quality of patient care.¹⁴⁴ A poll in June 1996 signaled the support for reform fell, and that 68 percent of Saskatchewan's residents did not like the way government managed the health system.¹⁴⁵ Taking note of the changed sentiments, the media observed that "...health care has exploded at the grassroots level this year unlike anything this province has seen for years."¹⁴⁶

Health reform had become a major political problem. Thus, by the end of the summer of 1996 unrest had taken hold leading even the media to question the government's wisdom in continuing with health reform:

...petitions and protests over hospital closures, the poor morale among workers barely coping with increased workloads even as the threat of more layoffs hang over them, doctors and therapists moving away because of stress and the government's own polling shows growing public concern over the health system... To the outsider, it must seem a project gone horribly wrong. Dr. Romanow's prescription for the ailing health system appears to be slowly killing the patient.¹⁴⁷

As a result, the government understood that continuing on the reform path could only lead to declining public support.¹⁴⁸

Hence, after a summer of intense and unrelenting pressure, on August 20, 1996, it relented. That day, the government announced an additional \$40 million in new funds for district boards.¹⁴⁹ This new funding was to "...mitigate the effects of the rapid restructuring...",¹⁵⁰ though in reality, the funding provided a much needed release valve for a system stressed by cuts.¹⁵¹ While the government argued that it had not reacted to public pressure, claiming the money came from higher-than-anticipated resource revenues, they did

acknowledge at the time that the pace of health renewal has been somewhat too fast.¹⁵²

However, clearly criticism of health reform had found its mark.¹⁵³ Health reform, as conceived in August 1991, had effectively ended.

Notably, the 1997/98 budget added \$70 million into health spending, with \$62 million directed to district health boards.¹⁵⁴ The infusion of funding continued in subsequent budgets. Moreover, the government abandoned its efforts at a transformation shift away from the medical model. Without stakeholder support, the more difficult second stage could not be achieved.

After five years, health reform succumbed to stakeholder holder pressures. These pressures clearly grew in step with concessions to stakeholders and just as importantly, concessions that corresponded with the provincial improving finances. Each budget offered more spending. Thus, while improved finances opened the door, so too did the unwillingness of government to shoulder the constant attacks by stakeholders. These attacks first shifted the media and then the public's views, ultimately wearing away at the government's confidence that it could survive these criticisms through the most important litmus test of future elections. Political expediency won over the sound policy of the health reform agenda.

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Chapter 5: Conclusion

Between 1991 and 1996 the Saskatchewan NDP government attempted to execute one of the most far reaching health reform policy agendas in Canada. The story of Saskatchewan's health reform is not, however, solely about the policy outcomes of reform, such as, for example, regionalization or needs-based funding. Instead, the analysis and narrative of the previous chapters demonstrate that under the NDP government health reform was a major policy undertaking, the implementation of which involved a mix of strategies and approaches indispensable to overcoming the many obstacles presented by a central and influential participant in Saskatchewan's health system: health stakeholders. In essence, the discussion illustrated that "how" health reform was implemented is just as, if not more important than the policy outcomes that the government hoped to achieve through its health reform agenda.

While much has been written about health reform policy outcomes, limited analysis has been undertaken on the mechanics of implementing health reform, and moreover, why those governments who have attempted health reform, have failed. Health care reform and its sound policy objectives are more often than not trumped by the political objectives of health stakeholders. Moreover, even those authors – Davidson, O'Fee, Adams and Wetzel – who have considered implementation and the integration of health stakeholders as important, omitted an analysis of the tactics and strategies governments adopted to manage health stakeholders through the health reform process. It may be possible that most health scholars find that contextualizing health stakeholders evolving and varying views, and their unpredictable nature, is too difficult and produces little new value. Ultimately, the outcome is the same. Though, Saskatchewan's health reform achieved small successes (regionalization,

system rationalization, etc.), on the whole, it fell short of its revolutionary wellness goals. Stakeholders prevailed over the government's agenda, again.

The complex characteristics of health stakeholders and the health environment make the adoption of a narrative or case study approach particularly effective in reducing the difficulty of this analysis and in producing a detailed picture of Saskatchewan's health reform experience. It creates a better representation of the vibrant, involved nature of government-stakeholder relations, and demonstrates the important dynamics between Saskatchewan's health stakeholders, the press and public opinion, and how those dynamics influenced the government's support of, or retreat from, Wellness. Despite the sound policy objectives of health reform it was the politics of health care – the political interplay of these stakeholders –that led the government to abandon its health reform agenda.

In fact it is important to remember, governments by their nature have the power to impose reform upon their citizens. This is especially true in Saskatchewan's case where the NDP government had a sizeable majority and thus firmly controlled the legislative tools needed to implement its reform agenda. Arbitrarily implementing reform, though, was not an optimal choice. Such an action would understandably lead to resentment, ill feelings, and in the end, result in diminished public support for the reform agenda, and ultimately, hinder the government's future electoral success. More importantly, a populist party like the NDP did not consider reform by fiat an acceptable option.

The problems associated with implementing health reform and managing the diverse and powerful health stakeholders help to explain why governments need a marshaling force or a motivating crisis to convince them of the necessity of proceeding with a reform agenda. In 1991 the NDP government faced circumstances that left it no alternative to health reform:

the province's finances. Simply, a fiscal crisis created both the unyielding pressure for change, and as well, the window of opportunity. From the beginning, the province's catastrophic financial state instilled upon the NDP government a sense of urgency that all public spending needed to be controlled – including spending to support health care. Thus, the fiscal crisis was a fortuitous occurrence for the NDP government. It became the anchor for health reform. It forced the government to act. It was a powerful factor in generating public support for dramatic changes in the health care system. And it made it difficult for stakeholders to oppose reform, at least in its early stages.

Moreover, health spending faced a chronic fiscal crisis of its own. Health care expenditures represented more than 30 percent of the government's spending and had, for years, grown faster than spending in other program areas. It also outpaced growth in the province's GDP. Thus, health spending was unsustainable and its contribution to the province's fiscal problems, undeniable. Moreover, health spending materialized partly because of an outdated and inefficient health system that had become resistant to change. Yet, it is clearly a system in need of changing. Its problems and failings and the necessity of reform had been evidenced by a number of provincial commissions and studies whose recommendations were supported by a large majority of health stakeholders. Therefore, understandably, health reform became an integral component of both restoring the province's fiscal health and of repairing the province's health system.

The fiscal crisis provided an opportunity by fostering public and stakeholder support for health reform. Polling showed that in 1992 and 1993 the public placed a higher priority on restoring the province's finances than on maintaining the health care *status quo*. Thus, health stakeholders found it difficult to oppose reform in its early stages. Maintaining the

support of the public became a key element of the government's reform exercise, as without that support, an NDP government became susceptible to pressures within its own party and from health stakeholders.

Financial pressure also played a role in elevating the sense of urgency for health reform, and thereby quickened the pace of many of the difficult and more problematic aspects of health reform. Some have argued that this damaged the government's reform effort and the government's credibility since it forced the government to intercede in, for example, hospital closures. This analysis suggests it was instead an advantage. For example, difficult choices such as hospitals closures, needs-based funding and program and service changes across the province, were implemented in a relatively short period of time, putting to an end, painful delays and anxiety. Essentially, Saskatchewan's fiscal crisis carried health stakeholders and the public through the difficult and agonizing decisions quickly.

While the fiscal crisis unquestionably underpinned Saskatchewan's health reform, the government also understood that health reform was a political process. Saskatchewan's health system was institutionalized and entrenched, the upshot of a community of vested, powerful, well organized and well funded stakeholders. Confrontation and conflict was an intrinsic part of that process and in order to succeed the government needed to control, anticipate, diagnose and respond to this dynamic stakeholder environment. By doing just that, reform lasted from 1991 until 1996 and along the way became a protracted policy process littered with messy interactions, compromises, concessions, contradictions and potential political pitfalls.

The government's approach to a successful health reform policy process was multifaceted, though a number of key strategies were critical. Central and probably the most

important aspect of health reform proved to be public relations and messaging. From the beginning, the government understood that it had to control and manage public perceptions of reform. Health stakeholders already had significant public credibility. Rightly so, their professions spoke of caring and nurturing, while they worked in environments where people trusted and relied on their knowledge and abilities. Conversely, politicians' of all stripes were regarded sceptically.

Stakeholders had good reason to be wary of the NDP government's motivations. Reform, in spite of its many positive connotations, contained numerous contradictions. Wellness actually enhanced, not reduced, the government's control of the health system through regionalization, which centralized a previously decentralized and very community-based health system. Oversight and province-wide coordination by the government increased. Community-based boards implemented needs-based funding that reflected a formulated set of objectives, while the government retained ownership for setting global funding levels for districts. Health board oversight aimed to take control of the system away from physicians, who had acted as the system's gate keepers. What is more, a fiscal crisis shaped reform and so cost reduction and restraint became the motivating force behind all of the government's decisions. Thus, on the whole, reform meant lost jobs, major changes and transitions, and disempowerment for many stakeholders in the health community.

As a result, managing reform through the dynamics of Saskatchewan's health stakeholder environment became the central strategy behind the success of the NDP government reform agenda. The government worked hard to convince stakeholders to support and participate in reform, or as a minimum remain neutral. Doing so meant aligning reform with stakeholders self interests as, the government understood, stakeholders would

support change so long as that change benefitted their member constituencies. However, just as quickly, stakeholders would oppose reform when it offered no benefits, or when it eroded their members' interests. Thus, keeping stakeholders on side involved the proverbial carrot-and-stick approach – catering to stakeholders' inherent interests, while when necessary, raising the specter of the fiscal crisis.

The government also used a range of other stakeholder management strategies. For example, it developed close relationships with as many stakeholders as possible, though, it again prioritized both SUN and the SMA for special attention. Special committees, meetings, discussions and open-doors ensured proactive dialogue on issues in order to preempt potential problems. The government's tactics also very effectively prevented stakeholders from unifying in opposition to health reform. Moreover, it averted unnecessary irritations for both stakeholders and the public with a smooth, methodical implementation process. Together, these strategies proved effective in mitigating problems that arose and easing some of the stresses associated with reform. However, none carried the same impact upon health stakeholders as the fiscal imperative.

Understandably, health reform's demise came because the government lost this fiscal imperative with the return of the province's financial health. Yet, the real retreat from reform began long before the province's fiscal recovery. As stakeholders became more critical of reform, their views were expressed in the press, which in turn fostered more critical press coverage of reform and public support for reform declined. As public support ebbed so did the government's commitment to health reform. The pattern was set in the 1993 and 1994 Budgets. In 1993 tough budget decisions led to cuts in health care and the closure of hospitals, which then led stakeholders to become more critical of the government.

By September and October, polls showed waning support for reform. In response, the government began its retreat. It caved in to doctors' demands that they be excluded from having to bargain with local health boards; a concession that struck at one of the key tenets of Wellness – local decision-making. Similarly, in the 1994 budget the government again retreated, scaling back cuts to acute care, creating a new \$10 million Rural Initiatives Fund and adding more money for home care. As well, the government signed an agreement with the RHC at a cost of \$1.1 million. The better news translated into better poll results in 1994. But the pattern was set. Angry stakeholders expressed their criticisms in the media, which in turn became more critical of reform. Public support for reform waned and the government backed away from making more difficult choices.

Managing the complaints of health stakeholders, even during the tough fiscal years, tested the government's ability to remain committed to its reform agenda. Simply, while each compromise served to momentarily moderate stakeholder anger, the fact of the matter was, only the fiscal crisis prevented a full scale attack by stakeholders and a retreat by the government.

The arrival in 1995 of the second consecutive balanced budget and a positive fiscal outlook simply intensified the stakeholder's pressures on the government. In essence, without a fiscal shield to underpin continued restraint, there was nothing to compel stakeholders through more reform. Good news clearly hurt a reform message anchored on a fiscal crisis. Furthermore, an election in 1995 required that the NDP government shift its messages away from fiscal constraint to the good news story of fiscal and economic success. Both the positive fiscal news and the election messaging could not sustain stakeholders through more years of difficult decisions and pain brought about by health reform. Frustrated

and angry, disillusioned and disheartened, SUN united with its nemesis, the SMA, and together their voices became singularly focused, joining with other stakeholders to vigorously oppose health reform. More importantly, with SUN's shift away from reform, the government lost an important ally and gained a powerful enemy.

This thesis then documents that, together, these stakeholders effectively created a palpable sense of crisis. Escalating and forceful stakeholders' criticisms into 1996, alongside the media's almost daily reports of these outpourings, eroded the public's support for ongoing health spending restraint. More importantly, stakeholders effectively contrasted the government's good news fiscal turnaround with reports of declining patient safety, bed closures that left patients out in the cold, waiting lists and delays, and physicians leaving the province. With these growing news stories, the government's polls clearly illustrated the shift of the public in the direction of rejecting health reform. By implication, the public's confidence in the health system fell, and so too did their support for the government. The government's political will disappeared. In August 1996 the NDP government halted its health reform agenda.

In the end, the narrative of Saskatchewan's five years of health reform shows that the government's reform efforts achieved mixed results. From a policy outcome perspective, the changes imparted by reform are somewhat positive. After years of having very little control of its health system, reform firmly implanted the government's oversight role. The government now managed the districts funding basket, and as well, set the benchmarks for those funds by implementing the criteria for and approving district budgets. The system revamped system rationalized services and facilities into a smaller number of health districts. Overall, a better organized system emerged.

Yet, the government also fell well short of completing a major component of reform; its Wellness agenda and the realignment of Saskatchewan's health system to focus on wellness, health promotion and health prevention. Moreover, the system still remained large and expensive, and after two years of cuts to the health budget, annual increases in health spending returned. These spending grew quickly, reaching pre-reform spending levels by the late 1990s. The success of health districts is also debatable. The concept of elected boards received tepid support from the public and a short number of years later, transformed into government appointed boards. In fact the value of the boards themselves is questionable, as they seemingly failed to envelope community leadership, instead, themselves becoming another bureaucracy and ardent stakeholder. Thus, reform's policy successes are debatable.

From a stakeholder management perspective, the lessons and outcomes are more certain. Key is that health reform was a product of a fiscal crisis, without which, the NDP would have never attempted such an extensive policy exercise. Thus, the marshalling force or fiscal anchor is clearly critical for health change. Moreover, the NDP government, because of its political skill and acumen, also managed to maneuver its health stakeholders through five years of health reform, and achieved some substantive change – again, regionalization, rationalization and control of the system. Together, the crisis and the government's political skills ensured that reform lasted longer and encompassed more than previous experience suggested possible.

Yet, the political costs of reform lingered long after. Relations between the government and its stakeholders permanently shifted, and never again will a Saskatchewan government receive the level of stakeholder support for health system change achieved by the Romanow government. In fact, in the years since, health stakeholders have become more

entrenched and defensive. Moreover, reform did not address the chronic nature of health costs. Simply, spending problems are long term in nature and thus require longer term solutions. Without these longer term solutions, health spending is destined to consume funds that would otherwise be spent on the very programs necessary to create a healthier population, such as education, poverty reduction or the environment.

Thus, implementing sound health policies requires an understanding of the political nature of the reform process. Again, a crisis or marshalling force is key. The fiscal crisis gave life to Saskatchewan's health reform and it held stakeholders to the difficult process. Equally a fiscal recovery ended that reform because in the health system the problems are chronic not acute. In essence, government's need to constantly identify new anchors for their health policy agenda or face losing momentum for change. The final value of this thesis is that it demonstrated the magnitude of the challenges governments face when they try to confront their stakeholders and change a health system. Simply, stakeholders are a significant obstacle to reform of the health system.

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